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THE PSYCHIATRIC QUARTERLY

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THE PLACE OF PSYCHIATRY IN THE CRIMINAL LAW*

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The topic to which I would invite your attention is not one which can be truly said to be novel; it is one, indeed, which has attracted many thinkers and one over which many a wordy battle has raged through many years. Mutual recriminations have been hurled between judge and psychiatrist, and editorial writers and reporters have not hesitated to use harsh language in referring to the part played by our specialty in certain criminal trials. Yet with all the criticism of the psychiatric expert which has been voiced (not always with full knowledge of the facts nor without malice, perhaps), progress has been made in organizing psychiatry into an instrumentality which may serve as a practical aid in the administration of the criminal law. It seems appropriate, therefore, to review briefly the historical relationship of psychiatry to the criminal courts, its present status and some of the laws and limitations under which it now operates, and by what developments it appears likely that it could be made more effective as an agency to aid in promoting the general safety and in securing a greater degree of justice to the offender.

As a preliminary disclaimer, it is probably superfluous to say that such a review can be only fragmentary; a vast literature on the various phases of the subject is available, the most of which has been epitomized and developed by Professor Sheldon Glueck in his masterly work, "Mental Disorder and the Criminal Law," published 10 years ago. On account of the highly specialized work of the juvenile courts, and the fact that they are governed by different principles from those embodied in the criminal law, the valuable contributions of Healy and Bronner and others to the progress of psychiatry in that important field will not here be dealt with. Time does not permit the naming of the host of significant contributors to the recent literature; some of them, such as Sachs, Bernard Glueck, Strauss, Jelliffe, Gregory, McCartney and Branham are perhaps present this evening; others, like White and Men-

*Presented as the annual address before the New York Society for Clinical Psychiatry, New York City, January 9, 1936. Published concurrently in Boston University Law Review.

ninger, are well known to us all. It is only fitting that I should mention particularly one who has recently left us and who did much to develop psychiatry as an adjunct of the law—Dr. Herman F. Adler. His career as the first state criminologist in the United States and as founder of the Institute for Juvenile Research in Chicago, to mention only two of his accomplishments, stand as monuments to his genius.* Thanks largely to the activity of men such as I have mentioned, we have already progressed far from the popular and judicial attitude expressed by the Lord Chancellor of England in 1862 in the words, "the introduction of medical opinions and medical theories into this subject has proceeded upon the vicious principle of considering insanity as a disease."[1] Just how far have we progressed?

Insanity, to use the legal term, has not always been available as a possible defense to criminal charges, even though it has been recognized in some form or to some degree for fully 600 years.[2] In the reign of Edward I (1273-1307) "lunacy" became a ground for royal pardon, although the goods of the convict were still forfeited, and it was not until the time of Edward III (1327-1377) that "madness" existing at the time of commission of the crime became established as a defense. With the recognition of the concept of irresponsibility by reason of "lunacy," certain criteria were developed by which to judge whether the accused person should be considered to be exempt from punishment on account of his abnormal mental condition. The confused state of these "tests" which exists today in many jurisdictions is no new thing; it is coextensive in time with the period during which "lunacy" and "insanity" have been recognized by the criminal law. The definitions depended to a large extent, of course, on the very elementary psychological concepts of the period, and may be said in general to have been strict, recognizing only the most marked types of mental alienation as justifying a finding of irresponsibility.

If time permitted, the evolution of the concepts and tests of responsibility would make a fertile subject for consideration. The analysis of crime into act and intent, or *mens rea*, came about by the

*Since these words were written, news of the passing of another leader in this field has been received—Dr. Walter N. Thayer, Jr. As commissioner of correction in Maryland and later in New York, and as a former president of the American Prison Association, he contributed substantially to a closer application of psychiatry to the problems of penology.

fourteenth century. If both coexisted, the offender, on the assumption that men are free moral agents, was rendered liable to punishment, or "responsible." "Madness" or "lunacy," or, as it came to be called later "insanity," if of sufficient degree and of the proper sort, could negative the guilty intent and thus exempt from punishment, i. e., render him "irresponsible." "A madman," according to Bracton's definition in the thirteenth century, "is one who does not know what he is doing, who lacks in mind and reason, and who is not far removed from the brutes." Hale, writing in the seventeenth century, indicated that no exclusive test should be laid down, but that the line should "rest upon circumstances duly to be weighed by judge and jury." He it was who first spoke of "partial insanity," a concept which, somewhat perverted from Hale's notions, has done much to confuse; he likewise suggested the importance of the volitional as well as the cognitive aspect. Hawkins contributed the idea of "distinguishing between good and evil," a feature which has been handed down since in various forms, and Erskine introduced the doctrine that delusion connected with the criminal act must be present. The trend, as Oppenheimer points out, had been toward greater leniency and humanity until the opinion of the judges in McNaghten's case.

The tremendous influence which has been exerted by this opinion through the years since 1843 is remarkable in view of the circumstances under which it was delivered. It was not a decision on a case, but consisted of the answers to certain general questions which were proposed *in abstracto* by the House of Lords, even though the case of McNaghten, a paranoid who had been found "not guilty on the ground of insanity," much to the public consternation, was undoubtedly uppermost in the minds of the judges and of the framers of the questions. One of the judges, indeed, objected to the method of replying, and Sir James Stephen considered the authority as "in many ways doubtful." Nevertheless, the substance of the answers is so thoroughly embodied in the law today that discussion of their authority is academic, even though some valuable lessons in the force and survival of tradition may be drawn therefrom! The best-known statement in the answers[3] is to the effect that to establish a defense on the ground of insanity

it must be proved that "the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it that he did not know he was doing what was wrong," the latter part of the question referring to the particular act charged. It is this latter proviso to which Oppenheimer[4] refers as a "retrogressive phenomenon," in view of the fact that the previous law had recognized an inability to distinguish between right and wrong in *general.* The judges added (a point often neglected) that the instructions should be "accompanied by such observations and explanations as the circumstances of each case require." Another answer which is the basis of much criticism dealt with those who "labor under such partial delusions only, and are not in other respects insane," while another propounds the astonishing doctrine that a delusion excuses, provided the situation assumed by the delusion would excuse if a fact. It was with reference to this proposition that the supreme court of New Hampshire remarked, "it is probable that no ingenous student of the law ever read it for the first time without being shocked by its exquisite inhumanity. It practically holds a man confessed to be insane accountable for the exercise of the same reason, judgment, and controlling mental power that is required of a man in perfect health."[5]

Although the English courts clung tenaciously to the M'Naghten Rules, a number of the American courts, following a logical course of reasoning, applied the tests to the act element as well, developing the "irresistible impulse" doctrine now recognized by nearly half of the states of this country. Recognition of this doctrine was recommended to the English Parliament by a committee in 1923,[6] but so far the dictum that "there is no foundation for the suggestion that the rule derived from M'Naughten's case has been in any way relaxed"[7] still holds true. From time to time, however, there have been glimmerings of light in the judicial gloom. New Hampshire[8] in 1871 boldly led the way toward a practical and full consideration of the mental status of the defendant by throwing over the "tests" and declaring that whether or not any alleged criminal act was the outgrowth of mental disease was a question, not of law but of fact for the jury. The decision in the case of State v. Jones is

a remarkable psychiatric document which is recommended to all psychiatrists; it concludes, "We have consented to receive those facts (of science) as developed and ascertained by the researches and observations of our own day, instead of adhering blindly to dogmas which were accepted as facts of science and erroneously promulgated as principles of law 50 or 100 years ago." Alabama[9] 15 years later followed a similar course of reasoning, after Connecticut[10] had declared its approval of considering "moral insanity" in determining the degree of crime, the court commenting that "the evidence may fall far short of proving irresponsibility and still satisfy the jury that the prisoner ought not to suffer the penalty of his crime." In another case[11] in which the defense was mental deficiency the same court advised the jury to consider *all the facts* brought to their notice bearing upon the defendant's mental condition. As recently as 1930 the New York courts[12] have upheld the admittance of feebleness of mind or will as a factor in reducing the grade of the offense, thus extending the principle of recognizing intoxication and heat of blood as interfering with the ordinary operation of a prisoner's mind. The courts, however, still stubbornly decline to recognize the unity of mental processes. Whether we refer to admitting "limited" or "impaired" responsibility, or whether we refer to reducing the degree of a crime by reason of mental impairment, the result of mitigating the punishment to the mentally handicapped is secured. The only disadvantage is that by the latter procedure no special treatment is provided, and that as a rule the psychopathic or otherwise pathological offender is subject to confinement for a shorter time, whereas perhaps he is the very one who should be confined for a wholly indefinite period! The popular notion that the psychiatrist wishes to see the offender turned loose upon society is far from the truth; many of those who are released at the expiration of sentence he would urge as candidates for prolonged segregation.

Even, however, with the promising exceptions noted, the "tests" are still generally adhered to with little room for deviation. A recent judicial pronouncement to illustrate follows: "Wherever the line of criminal responsibility of persons of low mentality may be drawn, one is either responsible or irresponsible. No definite idea

is conveyed by speaking of 'impaired' responsibility.'"[13] The concept of a dichotomy of the universe of offenders into the fully responsible and the hopelessly irresponsible still has many devotees among the judiciary!

Mental disorder being recognized as a defense under certain conditions, the problem of presenting evidence to the court on the subject arose. In the early days of the English law, the problem seems to have caused no concern. The judge was the dominant figure of the trial, and the jury were witnesses or at most "co-triers" of the facts with the judge.[14] Under such circumstances it was a simple matter for the judge to call in experts in whom he had confidence to advise him on specialized scientific matters. We find this done, for example, as early as 1353 in a case involving the nature of certain wounds. The expert, being called as a friend of the court, did not labor under the possible accusation or suspicion of bias. By the middle of the seventeenth century, however, the respective functions of the judge and jury had been modified, the jury becoming the judge of the facts, and the judge more of an umpire. The expert, possessed of special skill and knowledge, ceased to be an adviser to the court, and was presented by one side or the other as a witness to the jury. Thus, although the value of his knowledge was still recognized, he had now become a partisan, at least in the eyes of the jury. In view of the contentious nature of legal proceedings, it was to be expected that counsel would present only experts favoring their particular thesis. Quite aside from honest differences of opinion, the possibility of bias must be recognized, and the unfortunate though rare incidence of venality must be admitted. On the whole, it is not strange that the method of partisan introduction of expert evidence has brought suspicion on experts in general, and that as long ago as 1843 we find an English court saying, "Hardly any weight is to be given to the evidence of what are called scientific witnesses; they come with a bias on their minds to support the cause in which they are embarked."[15]

The lack of public confidence in expert testimony is based only in part on this element of partisanship. There are, of course, many types of expert, such as the specialist in handwriting, real estate values, engineering, chemistry, and other branches of science. Most

of these experts, however, are employed in civil cases, which attract little public attention and lack the dramatic features of the criminal trials in which psychiatrists are called upon at times to participate. To those who scold the psychiatrists for differences of opinion I recommend the perusal of the evidence given by real estate experts in some of the suits brought against states and cities for the recovery of damages arising from the condemnation of real estate—there the scope of the human imagination in its most sublime flights is demonstrated indeed! The opinion has been expressed by a prominent attorney of this city[16] that the problem of expert testimony in civil cases is considerably more difficult of solution than in criminal, since in the latter the State, as a party and as *parens patriae* has a direct interest in seeing justice done, whereas in the former it is only an arbiter between two private parties, each with his own motives for securing his ends, perhaps at any cost. In spite of the relative infrequency with which psychiatric expert testimony is employed, it is the psychiatrist who has to bear an undue share of the onus of public suspicion and attack. In a few highly notorious cases the defense of "insanity" has been offered; the offense alleged has been committed under circumstances of extreme atrocity, or the victim has been a prominent person, or for some other reason public feeling runs high against the accused. Often, indeed, the more the characteristics of the offense suggest to the psychiatrist the possibility of mental derangement, the more vociferously may the public, by a subconscious inability to identify itself with the offender, demand that "justice be done," or otherwise express its desire for a Roman holiday. The killing of President Garfield by Guiteau was perhaps an excellent example, and one does not require a memory of great length to recall other comparable situations. The defense in such a case is bound to be unpopular, and if the psychiatrist participates, he receives his full share of the hue and cry. A very few cases of this sort are to a large extent responsible for much of the emotionally-conditioned popular distrust of the psychiatric expert. The factor of differences of opinion is not a negligible one in this distrust. For some reason, many persons suspect the integrity of experts who do not agree, forgetting entirely the everyday examples of differences of opinion ex-

pressed by honest men in various other walks of life, from the justices of the Supreme Court down. The reasons why the lawyers are skeptical of psychiatrists are summed up by Michael as follows—their "extravagant claims"; unreliability of diagnosis; fantastic testimony; disagreement among them. He concludes rather naively, that "either those who disagree are not scientific or what they disagree about is not science."[17]

That these counts consitute but a weak indictment of psychiatry and psychiatrists will, I think, be agreed by anyone familiar with the facts. One could feel fairly safe in pleading "nolo" to such charges! As a matter of fact, many of the disagreements are more apparent than real, thanks to the hypothetical question, the refusal to permit the expert witness to explain his views and the reasons therefor, and other peculiarities of courtroom procedure. The hypothetical question, just mentioned, is the *bête noire* of the expert, calling as it does for an expression of opinion upon a synthetic robot with removable parts which is often as far from a human being, especially from the prisoner at the bar, as could well be imagined. Although this monstrosity[18] is dear to the hearts of legal casuists, one of the crying needs for an improvement of the expert's status lies in giving the witness a free opportunity to present the results and interpretations of his examination of the living individual who is the subject of the controversy at hand. Dr. White has attacked the problem so eloquently, particularly in "Insanity and the Criminal Law" that I refrain from further discussion of this point.

The differences of opinion just mentioned are often attributed by the laity to bias or to frank venality. The latter may, I believe, be disregarded for practical purposes as being extremely rare. That bias exists in everyone is a fact all too familiar to psychiatrists, and those who criticize the expert the most loudly should hesitate to cast the first stone on this ground. The average psychiatrist, I think, is likely rather to overcompensate for his presumed bias than to be unduly led by it. To assume, however, that difference of opinion *proves* bias is naïve. One of the fertile sources for disagreement in criminal cases is the rule which compels the expert to express his opinion on whether or not the defendant meets cer-

tain criteria of "responsibility" which, as we have seen, are based upon antiquated psychological concepts and which are essentially metaphysical rather than psychiatric. In a recent capital case in Massachusetts, for example, in which the defendant suffered from syphilis of the central nervous system, one of the examiners under the Briggs Law testified that the accused could distinguish between right and wrong "to a limited extent," while a physician from the hospital at which the accused had been observed swore that in his opinion he met fully the "tests" of responsibility. Here there was no ground for bias, both witnesses being impartial, and there was no fundamental dispute as to the findings, yet a difference of opinion developed on the relating of these findings to the 92-year-old "tests." So long as medical men are compelled to answer questions on such non-medical topics as "malice," "right and wrong," and "criminal intent," so long will the expert be placed in a false light, and full justice at times fail to be done the accused. Apparently, too, that hoary old legal dogma, the presumption of sanity, is hard to overcome. A recent pronouncement runs as follows: "the fact that a great majority of men are sane, and the probability that any particular man is sane, may be deemed by a jury to outweigh, in evidential value, testimony that he is insane."[13] One is moved to wonder just how convincing testimony must be in order to overcome the "probability" that the defendant is sane, and whether experts are of any use, anyway! If the presumption of innocence were as potent, who would be convicted?

As we have seen, there has been essentially no change in the so-called "tests of responsibility" during the past 50 years. There have been, however, various procedural modifications which have been enacted by various states in an attempt to produce some measure of reform at least in the method whereby consideration could be given by the court to the mental element of crime. Until such time indeed as the concept of responsibility can be modified and the so-called "tests" accordingly altered, procedural rather than substantive changes are all that may be expected. One of the earliest reforms attempted was that of the state of Washington, which in 1909 passed a law providing that the determination of sanity should be taken out of the hands of the jury, and that the

judge should be allowed to commit the insane or the feebleminded defendant to a mental hospital after the jury had determined that the act alleged had been committed by the defendant. In the famous Strasburg case in 1910[19] this law was declared unconstitutional on the ground that intent being necessary under the common law, as an element of crime, the defendant had a right to jury trial on the substantive fact of sanity. This decision was criticized by contemporary legal writers, first of all on the basis that since the defense of insanity has not always been available historically, the legislature presumably had the right to take away "intent" as an element of crime. It was further pointed out that the public has a right to be protected whether under the name of treatment or punishment. Nevertheless, the view adopted by the Washington supreme court apparently still held weight when a similar problem arose in the state of Mississippi only recently. There, in 1928, a law was enacted excluding insanity as a defense in murder trials, but the state supreme court promptly ruled this law invalid on grounds similar to those advanced in the Strasburg decision. The law was held violative of both the state and Federal constitutions, and the court remarked that if there is an abuse of the insanity defense, that is not an adequate reason for attempting an unconstitutional remedy, and that on the same reasoning alibi and self-defense, both notably abused as defenses, might as well be abolished![20]

The state of Louisiana in 1928 adopted a somewhat different approach by attempting to confer upon a lunacy commission absolute power to determine whether the accused was insane, withdrawing from the courts the power to determine the present sanity of the accused and withdrawing from the accused the right to urge "insanity" as a defense. This act, likewise, was declared unconstitutional—the court stating that the accused has a constitutional right to have his defense of insanity tried by a jury.[21] These are mentioned as rather extreme as well as unsuccessful attempts to solve, or at least ameliorate, the problem.

Certain other provisions have been adopted in certain states, although whether or not the purpose has been accomplished may remain an open question. In 1927 California (Penal Code, § 1016)

complicated the procedure to a very considerable extent, apparently in the belief that the abuse of the defense of "insanity" would be thereby reduced, by setting up provisions for a special plea and dividing the trial into two parts—the first on the issue of guilt or innocence of the act alleged, and the second, if the plea of "insanity" had been introduced at the appropriate time, on the issue of whether or not the defendant just found guilty of the act was of sound mind at the time he committed the act. The state supreme court, by rather casuistic reasoning, has upheld this law as constitutional,[22] although a considerable amount of criticism has been leveled at the procedure by legal authors. One judge of the supreme court said in a dissenting opinion, "The fact is that the plea of insanity has been destroyed. I said in my dissent that innocent people would be convicted under this procedure. The case before us is confirmation of that statement. A demented man has been convicted and sentenced to suffer the extreme penalty."[22] Another legal writer, apparently in a desire to be mild, admits that the procedure may prejudice the defendant's rights, (!) but adds that "it is fortunate that the 'due process' clause cannot be invoked to invalidate legislation enacted to remedy an ever-growing evil in the administration of the criminal law."[24] (!!) The provision is certainly far from fundamental, and probably the net result is merely to make it more difficult to obtain reasonable consideration of the mental state of the defendant. Another California law, enacted in 1929 (Penal Code, §1027) is undoubtedly good as far as it goes—relating as it does to the court appointment of alienists in the event that insanity is pleaded. One of these must be a member of a state hospital staff, and certain provision is made for limitation of the compensation to be paid.

In Colorado, in the event that a plea of insanity was introduced, the court must commit the defendant to a state hospital for a period of observation.[25] In an article by Henry Weihofen in the October, 1935, issue of "Law and Contemporary Problems" (Vol. II, No. 4, p. 419), a rather extensive study of the operation of this Colorado statute is presented which would indicate that the operation has been distinctly satisfactory. There is certainly every reason why a jury should have confidence in the report of the state hospital

which reports, not after a cursory examination but after a period of observation of about 30 days. Such a procedure is more thorough, and certainly much less expensive, than the employment of "lunacy commissions," as in New York, over the cost and composition of which some criticism has been had in the past. The Colorado statute is unique in that the commitment is compulsory upon the court, once the plea of insanity is entered; whereas the three other states mentioned by Weihofen in the article just alluded to, have permissive statutes only. As a matter of accuracy, too, it should be stated that there are other jurisdictions in the United States which have similar provisions. Massachusetts, for example, has had since 1849 a permissive law which is used freely by the court.[26] The mandatory provision of the Colorado act is undoubtedly a wise one.

Another Colorado statute which has its relationship to the preceding, is one of 1933 (Chapter 194) providing for a limitation of the fees of expert witnesses. In view of the fact that some of the popular criticism of the expert has come from the supposedly exorbitant fees charged, the principle of this law is probably sound. Such control of the fees of experts is within the power of the court, and is the rule in some other jurisdictions as well.

As for the right of the court to appoint experts, this is one which is found in a number of jurisdictions. Wisconsin, for example, has an excellent law on the subject; and there are other states in which this right, whether statutory or common law, has been upheld by the courts of last resort.[27] It seems reasonable to believe that this right is an inherent one, and so far as is known Michigan and Illinois are the only two states which have judicially denied this privilege to the courts.[28] The decisions denying this right have been vigorously attacked by Wigmore and other writers of outstanding importance, but as yet there has been no change in the attitude of these two states.

Methods such as those just described undoubtedly tend in the right direction and are in line with the provisions of the Keedy bill, proposed in 1916 by the American Institute of Criminal Law and Criminology.[29] Although it is quite likely that the defendant can never be deprived of the right of summoning as many experts

as he desires, it is entirely clear that the status of experts appointed by the courts or by some other official body, rather than presented by either party to the case, is bound to be more effective in presenting evidence to the jury. Nearly 30 years ago Dr. Oppenheimer, a profound student of this problem, went so far as to say that, "the practice peculiar to Anglo-Saxon jurisprudence of allowing experts in criminal trials to be instructed by and to be called on behalf of the party, lies at the root of practically all the avoidable evil of which such trials are productive. The only qualification required in this country (England) of an alienist expert is that he must be on the medical register."[30] The last sentence of this quotation brings up an important point—namely the matter of the qualifications of expert witnesses. At the present time the law is well settled that the qualifications of an expert are to be passed upon by the trial justice, and the matter is left entirely in his discretion whether or not he will admit an alleged "expert" to testify as to his opinions on a matter. The courts in general have been extremely lax on this point, and it is rather rarely that a so-called "expert" is not permitted to testify as such. The result has been, as was pointed out very clearly by Dr. James V. May in his presidential address before the American Psychiatric Association in 1933,[31] that many persons have testified as psychiatrists who in reality are not psychiatrists at all, and that some of the fanciful theories expounded by them have reflected upon the entire psychiatric profession. This question was discussed by Dr. Israel Strauss of New York in "Law and Contemporary Problems" for October, 1935 (p. 461), and the curious situation was pointed out by him that although the New York Code of Criminal Procedure provides for an examination in certain criminal cases by two physicians, at least one of whom shall be a "qualified psychiatrist, as provided by law," no law as yet provides for qualifications of psychiatrists! A bill is now pending in the Massachusetts legislature (House 40)* similar to the one which has several times been presented to the New York Assembly, setting up certain minimum requirements which are in brief either three years experience in a mental hospital or school for mental defectives, or at least five years in special psychiatric practice. If the courts would exert themselves to see

*Since passed by the house, but killed in the senate.

to it that only qualified persons were allowed to testify as experts before them, many of the criticisms now aimed at the psychiatrists would be avoided.

I am glad to pay tribute here to the splendid work of the American Board of Psychiatry and Neurology, of which your distinguished president is a member, for the work which they are doing to establish and cause to be recognized standards for those who hold themselves out to be psychiatrists or neurologists. History demonstrates that it is always better for a profession to have such standards imposed from within than from without.

The weakness of all of the schemes so far described is that the selection of the defendants to be examined is "hit-or-miss," depending as it does upon the initiation of a plea or upon action by the court which is, in turn, motivated by the report or claim of some non-psychiatric person such as an attorney, court official, or jailer. There is thus no assurance that the defendant who is actually mentally disordered will be recognized as such and examined; whereas, on the other hand, there is every inducement for the attorney who is desperate to enter a specious plea of insanity as a last resort—knowing perhaps full well that there is little or no basis for such a claim. That it is desirable for the court to have knowledge of the sort of human material with which it is dealing, preferably in advance of trial but certainly in advance of disposition, is almost axiomatic. It is probably likewise clear that the more nearly all of the cases coming before the court may be examined as a matter of routine, the more nearly will an accurate sifting process be carried out.

It seems in order to describe briefly at this point the Massachusetts procedure known as the "Briggs Law," which represents the first instance in which the principle of automatic examination has been enacted into law.[32] The statute, which was written by Dr. L. Vernon Briggs of Boston, and which was enacted by the Massachusetts legislature in 1921, provides that all defendants falling within certain named legal categories, to wit, "all persons indicted for a capital offense and all persons who are bound over or indicted who have previously been convicted of a felony or who have previously been indicted more than once for any offense" shall be re-

ported to the department of mental diseases for mental examination. In the case of those bound over, it is clearly intended that the district court as the court of first instance shall make this report. In all other cases the report is made by the superior court—the intent of the law being clearly to have the report, which is accessible to the district attorney, the counsel for the defense, the probation officer of the court, and, of course, the judge, available before the trial commences. The probation officer is made responsible for informing the clerk of the defendant's previous record; this information is readily available to the probation officer through a very efficient central record system maintained by the state board of probation. The wording of the law is interesting, in that it directs the department to determine the mental condition of the accused, *and* "the existence of any mental disease or defect which would affect his criminal responsibility." The statute thus calls for a much broader report than a mere statement that the prisoner is or is not "insane," and apparently contemplates that all the significant data bearing upon the mental condition of the defendant shall be made available as an aid to the court. In addition to the fact that the law is intended to operate upon all, regardless of claims as to sanity, who fall within the specified legal category, it should be pointed out that the examination is made by psychiatrists who are appointed by a professional organization—namely, the Department of Mental Diseases of the Commonwealth, and who are not representatives of the court or of either party. The matter of impartiality, is therefore, clearly provided. Furthermore, the fact that the psychiatrists are selected by a group which is presumably well fitted to pass upon their professional qualifications assures the competency of the examiners. The fee which is allowed—namely $4 per examination—is so small as to be negligible, and does not constitute any large expense to the county as a result of the operation of the law. On the other hand, the savings resulting from the operation of the statute have been ample to repay many times over the cost of administration. If a defendant is found to be suffering from mental disorder, he is promptly committed to a mental hospital, where he is kept until such time as he may be tried. If he

does not recover, there is no trial and in many cases the expense of trial, which might well be considerable, has been obviated.

There have been instances where defendants were found to be suffering from mental disease whose own attorneys had not even suspected the state of affairs; and in one very startling case involving the killing of two police officers, it is quite likely that the defendant who was suffering from a rather advanced case of dementia præcox might well have gone to the electric chair, had it not been for the findings resulting from this examination. The report itself is not admissible, but the psychiatrists who submit it may be summoned by either party to testify as to its contents and their opinion. It is obvious that the testimony of the examiners may well be looked on by a jury with favor, since they know the witnesses not to be partisan. As a matter of fact, in the very few cases where the defense has availed itself of its constitutional rights to introduce the evidence of partisan witnesses the jury has chosen to believe the experts appointed by the department of mental diseases in preference to those employed for the defense. The district attorneys have practically every time followed the advice of the examiner and have relied upon their testimony rather than introducing a battery of other experts. The outstanding advantages, in brief, are justice to the mentally disordered defendant, the practical elimination of "battles of experts," and a substantial saving in expense resulting from the avoidance of unnecessary trials; of almost equal importance has been the opportunity presented by means of clear, simply-worded reports, to educate the judges and attorneys in the real purposes and values of psychiatry as an aid to the courts.

The law has been amended from time to time to improve its administration, but the principle has not been altered. Up to October 15, 1935, 6,068 cases have been reported, of which 5,159 have been actually examined. A fair number of the defendants not examined were on bail and could not be located by the examiners, and a scattering number refused or had, through oversight, been disposed of before the examination could be completed. Over this period 69 defendants have been reported to the court to be insane. In 169 additional cases, commitment to a mental hospital for a period of observation has been recommended; 432 have been reported to be

mentally defective; and 100 have been reported as suffering from other mental abnormalities, such as borderline intelligence, epilepsy, drug addiction, psychopathic personality, and so on. This makes a total of 760 cases, or 14.7 per cent of all those examined. These figures are cited as presumably fairly representative of the "run of the mine" of the more serious offenders, if indeed, the term "felony" or the conception of previous conviction is an adequate index to seriousness of offense. The supreme judicial court of Massachusetts has in several instances considered questions relating to the operation of the Briggs Law in criminal cases, and has on each occasion spoken of it with approval. It has taken judicial notice of the fact that there is every reason to assume that the examination will be made by competent persons who are free from any disposition or bias, and under every inducement to be impartial. In another case, it was implied rather strongly that the report should be practically final, when it sustained the trial justice in refusing a motion to allow the expense of further experts to examine the defendant after the Briggs Law report had been filed,[33] and had the clear intent of this ruling been followed in another case, Massachusetts would have been spared one of the very few "battles of experts" from which it has suffered recently. It has also been held that the examination does not compel the defendant to give evidence against himself in violation of his constitutional rights.[34] As a matter of fact, a defendant may refuse to permit an examination, although this is extremely rarely done. If the machinery were available it might be desirable to extend the scope of the Briggs Law to include all felonies, as has been recommended by the criminal law section of the American Bar Association. Even with the limitation as to the scope of the act which now exists, there seems to be no doubt both in the minds of those of us who have had practical experience with the Briggs Law, and in the minds of legal writers, that this statute is the most progressive legislation yet enacted looking toward a closer union of the law and psychiatry.[35]

As another scheme of routine examination I may refer to the psychiatric clinic in the court of general sessions in New York City. The clinic, after many years of struggle, was finally established

and now operates under Dr. Walter Bromberg of the Bellevue Hospital. The court of general sessions is said to be the largest criminal court of superior jurisdiction in the country, and the clinic has been set up for the purpose of examining before disposition every person convicted of a felony in that court—the number being approximately 3,000 a year. I am informed that about 3 per cent of the convicted persons examined are found to be mentally defective, or to be frankly psychotic; and that another 3 per cent are found to be in what might be termed the borderline group —that is, dull mentally, suffering from hysteria, psychopathic personality, epilepsy or drug addiction. The judges have apparently cooperated excellently, arranging to send the psychotic prisoners to a mental hospital and most of the mentally defective ones to an institution for defective delinquents. The reports have evidently been made to the judges in simple language, so as to convey to the judge the facts of the situation without confusing verbiage—an extremely important matter which might well be borne in mind by all who have occasion to come in contact with the courts.

The present status of court clinics in the country at large cannot be accurately given, as recent figures are not available. In 1928 a questionnaire survey conducted by the National Crime Commission indicated that of 1,168 courts of all grades of criminal jurisdiction (including juvenile courts) 110, or 9.4 per cent, reported themselves as employing a psychiatrist, either whole or part time. On further inquiry it appeared that 26 out of 45 courts furnishing the requested data examined less than 10 per cent of the defendants disposed of. The comments of the judges on their opinion of the value of psychiatric advice as an aid to disposition were requested, with the result that 473 out of 584 judges replying recorded themselves as frankly favorable.[36]

It seems elementary to expect that a court, if it hopes to do a reasonably successful job, would wish to have available information as to the personality and assets and liabilities of the defendant, in order to dispose of the case for the best interests of both society and the offender. One difficulty is, however, that in spite of the establishment of mental hospitals for the psychotic offender, and of institutions for defective delinquents (a sphere in which New

York leads), for the defendant who, though clearly abnormal mentally is not definitely classifiable in either of these categories, the court has little or no option as to disposition. The clinic may be helpful to the probation department if the defendant is placed in their charge, but the types of institutions and the terms for which confinement may be ordered are all too limited. There still lingers in our penal law too much of the influence of Beccaria, with his tenets of prejudged penalties and of penal equivalents. Greater discretion must be given to our judges and a greater variety of institutions be made available before the full advantage of psychiatric advice may be taken. On the continent, notably in Holland and Belgium, where the influence of Ferri and the positivist school has been felt more strongly than here, steps along these lines and away from the concept of "punishment" have recently been taken. It is to be hoped that similar advances may eventually be made in this country. The development of reformatories, of institutions for defective delinquents, and inebriates, and of the indeterminate sentence all point the way toward a more individualized treatment of the offender, but much remains to be done before the adjustment of the treatment to the offender's needs reaches a satisfactory stage.

The treatment of prisoners following conviction is, technically, not a part of the criminal law at all, but properly belongs in the field of penology. It is, nevertheless, so closely related to the topic in hand that a brief consideration seems desirable at this point. Since 1908, when Guy Fernald first started his work as psychiatrist at the Massachusetts Reformatory, followed closely by A. Warren Stearns at the Massachusetts State Prison, and by Bernard Glueck at Sing Sing, the field of psychiatry in penal institutions has developed to a very considerable extent. There is every reason why this should be so, for the correctional and penal institutions are dealing with a mass of human material, and there is a widespread feeling that the success of their methods of dealing is none too great. Until such time as the courts become more generally and thoroughly equipped for psychiatric advice, it is inevitable that a substantial number of prisoners should be sent to penal institutions who should properly have been committed to mental hospitals or to other specialized institutions instead. As a sorting device,

therefore, even if nothing further can be expected of it, the position of psychiatry within the institution would seem to be secure. There is much more than this, however, which may be done. Questions of classification, of disciplinary action, of recreation, and of vocational guidance, are matters which call for psychiatric advice and can be considerably aided by it, particularly if any serious attempt is made by the prison administration to coordinate this professional activity with the other activities of the institution.

The survey made by the National Crime Commission[37] in 1928 included correctional and penal institutions as well as criminal courts, and indicated that of 259 institutions which were studied, 93, or 35.9 per cent, employed psychiatrists on either a full-time or part-time basis. One hundred and twenty-nine of the superintendents, or 50 per cent, expressed a favorable opinion of the value of ascertaining the mental, nervous and physical condition of prisoners as an aid to their classification and disposition—a fact which is of some little interest in comparison with some rather extreme remarks made recently by a prominent penologist, which will be referred to again later.

In 1934, Dr. James L. McCartney, then psychiatrist at the Elmira Reformatory, made a similar survey which indicated only a very slight decrease in the employment of institutional psychiatrists. He found 48 full-time psychiatrists in 13.4 per cent of the institutions, and 35 more on a part-time basis in 13.9 per cent of the institutions, or a total of 27.3 per cent as compared with 35.9 per cent, as found in 1927.[38] Since 1931, the United States Public Health Service[39] has operated a psychiatric service in the Federal prison system with results which are apparently extremely satisfactory. Each inmate is examined thoroughly from the psychiatric and psychological points of view, and these reports are made available to the other departments of the institution, becoming an integrated part of the institutional program. The psychiatrist and psychologist are represented upon the classification and disciplinary boards, so that the services are practically applied to problems of custody, discipline and corrective treatment. Thanks to the cooperation and understanding between the administrative officials and the psychiatrists in the Federal prison system, psychiatry is apparently

being made there a valuable agency in the rehabilitation and constructive treatment of offenders. That the psychiatrist who has had the offender under observation for a period can give valuable information to a parole board which is considering the matter of release, is probably, likewise, a fair statement. In view of the constructive experience in a material number of institutions, and the testimony of prison administrators, it is distressing to hear a jarring note sounded by the head of your largest State penitentiary in New York, an institution which under the leadership of Dr. Bernard Glueck, early demonstrated its significance in the field of penology. Recently Warden Lawes, in addressing the American Prison Association, said,[40] "In my experience as a practical prison administrator, I have observed some of these gentlemen of evident learning propound theories, give tests, issue I. Q.'s, and introduce numerous other plans without any appreciable constructive work resulting from their labors. Often, the antagonism aroused in the average prisoner by exhaustive, searching, indelicate, and revolting questions, tends to nullify what good psychiatry might accomplish —in all fairness to psychiatry, this may be due to the regrettable fact, that the personnel of a prison resents the intrusion into their relations with the prisoners of an element that is entirely strange and incomprehensible. They can only see that the average prisoner, after an interview with the psychiatrist, is resentful, sullen and intractable. Humanization and rehabilitation must go on, but psychiatry must prove itself less academic to become a definite and positive factor in this respect." One can only wonder how much of a genuine effort has been made on the part of the administration of the prison to understand the purposes and aims of psychiatry, when it is admitted that this element is "incomprehensible" to the personnel of a prison! Perhaps if a genuine effort were made to incorporate the psychiatric clinic at Sing Sing prison as an integral part of the work with the inmates, a different verdict might be rendered by the head of the institution.

Even if the psychiatrist is not accepted as an aid in classification, discipline and recreation, it would appear from such statistics as are available that a fertile field is offered from the point of view of diagnosis and psychiatric treatment in the population of an in-

stitution. Dr. McCartney, for example, in the annual report for 1932-33 of the work of the classification clinic of the Elmira Reformatory, stated (p. 112) that out of 553 cases examined, 9.8 per cent were feebleminded; 1.4 per cent suffering from postencephalitic disorders; 1.4 per cent chronic alcoholic; 6 per cent potentially psychotic; 0.5 per cent having the traumatic personality. A diagnosis of psychopathic personality was made in 36.55 per cent of the cases. Until the criteria for the diagnosis of psychopathic personality are somewhat more generally agreed upon by psychiatrists than is now the case, it will be well to be rather sparing in the application of this particular term.[41]

One group of prisoners which has been rather systematically neglected has been the population of the county jails. According to the Federal census,[42] 72.8 per cent of the inmates of state prisons, reformatories and county jails are in the two former types of institution. On the other hand, 91 per cent of the commitments made to these institutions during the year are made to the county jail. There would thus seem to be a tremendous turnover within a short space of time in the county jails, and the rate of recidivism is notoriously high. Massachusetts is the only state ever to have made a systematic study of the convicted prisoners in the county jails, this study having been made through the division for the examination of prisoners of the department of mental diseases during the years 1924 to 1933, a division which was abolished in the latter year on the ground of economy. Some of the outstanding groups of the male prisoners in that study were as follows:[43] alcoholism without psychosis, 37.8 per cent; low normal, or borderline intelligence, 9.1 per cent; mental deficiency, 7.5 per cent; drug addiction without psychosis, 1.2 per cent; psychosis, 3.2 per cent; psychopathic personality, 15.5 per cent. In other words, even if we omit the alcoholic, 20.1 per cent of the men and 38.9 per cent of the women were suffering from mental disease, epilepsy, mental deficiency, or at least low normal or borderline intelligence. If we add the alcoholic, the drug addict, and the psychopathic personality, a painfully small portion of the group can be said to approach the normal mentally. In the face of such figures, it seems hard to doubt that psychiatry has a very definite place in penal and correctional insti-

tutions. That mental abnormality is not the principal cause of criminality is true,[44] yet there seems little doubt that deviations from the norm are a factor in a measurable number of cases of offenders against the law, or at least of those offenders who are apprehended and convicted. From the point of view of prevention of further criminality, and from the point of view of immediate treatment, if nothing more, the services of psychiatrists in penal and correctional institutions seem amply justified.

The inference should not be drawn from the preceding remarks that one need be pessimistic concerning a closer rapprochement between the law and psychiatry. Very definite steps are being taken which are of a constructive nature and which offer considerable promise for the future. In 1927, at the instance of Dr. Karl Menninger, who was then chairman of the Committee on the Legal Aspects of Psychiatry of the American Psychiatric Association, the criminal law section of the American Bar Association appointed a committee on psychiatric jurisprudence, which since that time, has met at least annually with the committee of the American Psychiatric Association, and with a committee which was appointed in 1929 representing the American Medical Association. The interest and the cooperative spirit displayed by the representatives of the Bar Association have been most encouraging and heartening. Several constructive recommendations have been made by that committee which have been presented to the American Bar Association and approved in principle. In 1929, for example, the following recommendations were approved by the American Bar Association:[45] (1) That there be available to every criminal and juvenile court a psychiatric service to assist the court in the disposition of offenders; (2) That no criminal be sentenced for any felony in any case in which the judge has any discretion as to the sentence until there be filed as a part of the record a psychiatric report; (3) That there be a psychiatric service available to every penal and correctional institution; (4) That there be a psychiatric report on every prisoner convicted of a felony before he is released; (5) That there be established in each state a complete system of administrative transfer and parole, and that there be no decision for or against any parole or any transfer from one institution to another, without

a psychiatric report. These recommendations are of particular interest to psychiatrists, since they originate with a group of lawyers rather than with members of the medical profession. They illustrate the interest displayed by the progressive members of the legal profession in the aid which psychiatry may render to the law.

Another pronouncement of psychiatric interest is the adoption in 1934 of the following resolution by the criminal law section of the American Bar Association,[46] "That it is desirable to keep within rather narrow limits the kind and degree of mental disorder which will entitle the defendant in a criminal case to an acquittal, and to readjust the machinery after the point of conviction to the end that mental disorder which is not sufficient for an acquittal may result in treatment other than that provided for persons who are not mentally disordered." A committee of the New York Academy of Medicine has for several years cooperated and conferred with a similar committee of the New York Bar Association, and only a little over a year ago, a symposium was held on this very topic at which the attitude of psychiatry and the criminal law were well presented by Dr. Bernard Glueck and Mr. Jerome Michael.[47] A committee on medico-legal problems (other than psychiatric), has been set up by the criminal law section of the American Bar Association and that committee has drawn up a model expert testimony statute, which is worthy of careful study by those who desire an improvement in procedure.[48] Most promising, likewise, is the introduction into a number of law schools of courses in psychiatry. In this manner, eventually, the rank and file of the bar may be sensitized to the value of this specialty of medicine in their work.

Ultimately, of course, the changes which take place must be more than procedural. Procedure can do much to utilize the existing framework, but the framework of the criminal law still savors too much of the medieval to be brought readily into rapport with psychiatric concepts of the present day. In the discussions which have taken place, much favorable comment has been made upon the concept of a treatment board, such as was given wide publicity by Ex-Governor Alfred E. Smith in 1928, a board, that is, which would pass upon all matters relating to the treatment of offenders, the courts being given only the prerogative of determining guilt or in-

nocence of the act alleged. As a corollary, special institutions and a truly indeterminate period of detention would be needed, with some safeguards against abuse of the writ of habeas corpus. In view of the Strasburg decision, it is likely that such a development will have to be postponed for some time, as there are constitutional objections, but it would seem that in the end some such scheme will be adopted, for notions of punishment, must eventually give way to the concept of social security and individualized treatment of the offender. It is this very concept of punishment, indeed, which is responsible for much of the argument and misunderstanding over the matter of responsibility, which in the last analysis, means merely liability to punishment. As a first step, it is quite likely that the abolition of capital punishment would do away with most of the difficulties of expert testimony which now exist, in view of the fact that it is almost entirely in cases involving the possibility of the death penalty that the defense of insanity attains notoriety and widespread attention, with resulting public condemnation of the psychiatrist.

It will readily be seen from our review that substantial progress has been made in establishing psychiatry as a helpful adjunct to the criminal law and to penology. To this end our profession has contributed its full share, in spite of the obstacles presented by legal tradition and the differing fundamental concepts of law and of medicine. Certain progressive laws have been enacted, and certain changes of procedure and administration have been effected. Under the guidance of psychiatric knowledge, it is sincerely to be hoped and expected that ultimately new fundamental concepts of the nature of crime and the purpose of peno-correctional treatment must prevail; that less emphasis will be placed on punishment and more on treatment; that limited responsibility will be recognized, or better that this vexed question may be entirely eliminated from consideration during the trial; that broader discretion may be given to judges, and that a wider variety of dispositions and specialized institutions may be made available to them or to a "treatment board." In the meantime it behooves us to avoid so far as possible even the appearance of partisanship, to act in our historical capacity of friends of the court, and to exhibit a due conservatism in

advancing psychiatric theories and claims. Enlightened members of the legal profession are desirous of promoting a closer union of our specialty with the criminal law; in cooperating with them in achieving this aim we have not been, and must not be, wanting.

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TRENDS IN PSYCHIATRIC RESEARCH*

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Particularly when a fatal catastrophe is brought about by a mentally disordered person or when burdens of taxation for the care of the mentally ill and handicapped are brought to attention, the temporarily interested public is apt to ask psychiatrists: "What is the cause of this tremendously increasing burden, and what are you finding out about the insane and how can you stop insanity and how can society be protected from the dangers and the burdens of so-called insanity?" It is of little use to point out that the mentally disordered have always been with us and probably always will be, or to counter with the question: "Have all the problems of economics and politics been solved and if not, why not?" To many, mental disorder has so much of mystery in it that it cannot be viewed from the standpoint of economics or politics. However, one may cite figures to combat to some extent the impression that mental disorder is so greatly increasing. Although between 1912 and 1934 the number of persons admitted for the first time to the New York State civil hospitals increased by 87 per cent, the number of cases admitted per 100,000 population increased only 27 per cent and the increase was principally in the old age group, that is, the arteriosclerotic and senile types. This increase is apparently largely due to the increase in duration of life, 10 years having been added to the average life since 1900. The longer persons live, the more chance there is of developing mental disorder requiring hospital care. The remainder of the increase may well be due to the change in attitude toward hospitals, the increase of urban population at the expense of the rural population, and economic conditions, all of which tend to bring more persons into mental hospitals than formerly. It is doubtful therefore, whether there has been a real increase of incidence of mental disorders during the past 20 years. Certainly the absolute increase in hospital admissions is not a real criterion of the incidence.

However, the question of what is being done in psychiatry and

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what can be done—in what direction psychiatry will devote its investigations in the next 10 years—is a reasonable one and it is toward an answer to this question that we wish to direct our attention today.

It is unnecessary to recall to you the advances that have been made in the treatment of general paresis. The prevention of this disease of the central nervous system involves essentially the prevention of syphilis. If the latter could be eradicated by education and prophylaxis there would be no general paresis but such an eradication cannot be expected in the next 10 years and for the next 10 or 20 years we may expect to have to treat because of general paresis, persons who are today being infected with syphilis. Early treatment may prevent general paresis in those infected, but such a proportion of persons contract syphilis without their knowledge, and therefore receive no early treatment, that early treatment is not the complete answer. We do not know now why certain syphilitic persons develop paresis and others not, irrespective of treatment. This is one of the important problems for the psychiatrist working with the immunologist and bacteriologist, to work out in the future. If the problem of the immunity of the central nervous system to syphilis can be solved, and application made to artificially or naturally increasing this immunity, there may eventually be no cases of general paresis even though syphilis may continue as a medical and social problem.

If by preventive methods of public health we are enabling more and more persons to live to an old age, what can be done to prevent their mental decay in the senile period? I have previously rephrased the biblical query to "What shall it profit a man if he add 10 years to his life and lose his mind?" There is good evidence to make one believe that this senile decay is a state of an excess of breaking down of tissue over building up of tissue—a matter of the chemical processes of the body. The biological chemist may be looked to for the solution of the problem of finding means of a continuation of the constructive building up processes by diet or other chemical means to at least postpone this ageing process. Carrel has said that at least for mice, a diet that promotes growth, the size of litters, and a decrease in the incidence of pneumonia

does not promote longevity and that on the other hand, diets that do not promote these factors, do seem to lead to longevity.

For the prevention of the mental disorders associated with, or due to, cerebral arteriosclerosis we look to the internist, the chemist and the surgeon. If arteriosclerosis could be prevented, we would not see a continuation of the marked increase in arteriosclerotic mental disorders that we have had to care for. Whether the apparent innate tendency to early arterial degeneration in some persons can be prevented remains to be seen, and whether regulation of diet and of living habits or removal of the thyroid, or cutting of certain sympathetic nerves or surgical procedures with the adrenal glands can reduce the incidence of arterial degeneration, and mental disorder, remains for the further use of these modern methods of medicine to answer.

Studies during recent years particularly have demonstrated the importance of diet and vitamins in the development of alcoholic toxic psychoses with neuritis, and of pellagra. It is fairly well known now that persons may drink large amounts of alcoholic liquors without developing toxic reactions as long as they maintain a well-balanced diet. When food is not taken or is not assimilated, such persons may soon develop toxic reactions with more or less severe neuritis: the treatment, directed particularly toward saving life in the acute stages, consists of feeding with a high vitamin diet, and the injection of these by liver extract or viosterol where they cannot be assimilated from the gastro-intestinal tract. With this understanding the incidence of these reactions may be decreased, and where the toxic reactions may have already developed, the death rate reduced. Further studies need to be made on these and other nutritional disorders, which show symptomatology of toxicity. Chemical investigations on detoxification in these conditions are on the way in our chemistry department and their continuation, it is hoped, will lead to further knowledge and subsequently to improved methods of treatment.

Although progress has been made and will be made in the knowledge of all of these disorders which we call the organic reactions, merely from the standpoint of numbers of patients involved our greatest problems remain with the so-called functional, or, as we

prefer to call them, the constitutional disorders. These are essentially the manic-depressive, the dementia præcox, the psychoneurotic and the psychopathic reactions. From our standpoint the dementia præcox reactions are the most important of these. Kraepelin, Jung and Bleuler and most German psychiatrists have looked upon dementia præcox as a disease entity, due primarily to some disease process, the cause of which was unknown but "intoxication" of some kind was suspected. Kraepelin's conception was based in part at least, on the reported degenerative brain changes found in cases of dementia præcox. Careful investigations of Dunlap and Spielmeyer showed that the same so-called changes were found in normal persons dying suddenly by accident or otherwise and one is justified in saying, we feel, that there is no demonstrable specific brain pathology for dementia præcox. There is no substantial evidence that dementia præcox is a disease in the sense of having a specific etiology and definite pathology and course. The trend of psychiatric research is today directed toward dementia præcox as a group or groups of constitutional reactions—that is, inadequate and distorted reactions, largely on a psychological level but as a part of the constitutional inadequacy—the inadequacy of the human organism in its constitution or make-up, to respond properly to the demands made on it.

There is no special reason to believe that the psychological, economic and social experiences or demands for adjustment are in the long run different in those who develop manic-depressive or dementia præcox reactions, than they are in those who do not break down but rather that the responses to these same demands are different in those who develop what we call mental disorder. We feel that such disorders had best be looked upon as reactions of the human organism rather than disease entities, responses of an organism to demands upon its make-up or constitution. An organism that is not so constituted as to make an adequate response, fails entirely in such response, or makes a feeble or a distorted attempt. We have been concerned over the past years with studies of the habits of response as shown by the thinking and feeling of those who eventually break down and have emphasized that such persons have from their early lives developed faulty habits as far as their

adjustments have been concerned. Psychiatry is at the present, and will be in the future, concerned with determining to as high a degree as possible, the reasons for these faulty responses with their inadequacies and distortions. Constitutional medicine has, particularly in recent years, emphasized the relation of body build and temperament, Kretschmer especially pointing out the relationship between the long, narrow, or *asthenic* type of body build to dementia præcox and on the other hand, the short, broad or *pyknic* type to the manic-depressive reaction. It seems worth considering that the asthenic type of person is essentially the one who is not prepared to combat, or respond to, the environment and he is limited in his capacity to make such response, particularly in muscular activity. It is not insignificant perhaps, therefore, that the asthenic type of person is apt to be the esthetic type of person, the intellectual type or introvert rather than the extravert or more outward-going person. Studies by Lewis and others have tended to show that such persons have internal somatic evidence of a limited capacity for response, demonstrable in the poorly-developed cardiovascular system and at times at least, in poorly-developed glands of internal secretion, which glands have at least something to do with the drive and energy and growth of the person. Such evidence of internal organ incapacity or lack of development has not as a rule been demonstrated in persons who are prone to develop the manic-depressive reactions.

The withdrawal from contact with the environment or from reality by certain persons whom we later recognize as cases of dementia præcox, may be due, therefore, to fundamental incapacity for doing much, if anything, else because of their fundamental constitution and incapacity for activity. There is certain evidence that many persons who are classified as having psychoneurotic reactions tend toward the same inadequate constitutional type of development. Their responses to stress and strain and their responses as measured by physiological methods which test their capacity, tend toward the type of responses shown by those whom we recognize as dementia præcox. For example, it has been more recently shown with tests of neurocirculatory response and the reaction to the administration of low oxygen, similar to that obtained at high

altitudes that the results may be much the same in persons who are looked upon as psychoneurotic as in those who are classified as showing dementia præcox reactions. Psychoneurotic symptoms may be attempts at a substitution or escape from meeting demands that cannot be adequately coped with.

It may also be pointed out that there is certain evidence that a psychological attitude toward sex can be connected, to a certain extent at least, with a somatic or sexual organ development and that those who maintain an immature, infantile attitude toward sex and never reach adult sexual development psychologically, may likewise have an inadequate physical sexual development. Also, that those persons who show psychosexually homosexual tendencies may have physical evidence of a distorted or dysplastic sexual development with tendencies toward the physical development of the opposite sex. There is certain evidence also that the internal secretions of such unbalanced persons may show abnormalities. With the knowledge then, that the human organism like other organisms, can respond only according to its capacities and that its incapacity lies within its constitutional development, psychiatry, we feel, should have its interests directed more and more toward investigations of the nature of these responses and capacities for responses of the individuals who are showing evidence of unfortunate responses in mental disorder.

Clinical psychiatrists in the study of psychological responses should, we feel, be assisted more and more by the biological chemist and the physiologist in testing and evaluating the responses and the reactions of psychiatric patients under various tests in modifiable conditions. With the prosecution of such studies it is felt that not only will more of the nature of these constitutional disorders be understood but also that knowledge will be gained regarding the modifiability of the responses and capacities of the individual with the possibility in mind of training these persons gradually for more and more adequate responses not only of psychical nature but of a physical nature so that their organisms may be re-educated as it were, to better meet the demands made upon them. Or, if it is found that the capacity of the individual cannot be increased, the knowledge of the limit of capacity may enable one to adjust the

individual in a situation where he will remain within that capacity and not be put under more stress or strain than he can withstand.

We feel that although certain advantages have been gained in classifying reactions under various clinical heading of the dementia præcox, manic-depressive and psychoneurotic groups, at the same time it would be unfortunate if we continued to look upon these reactions as disease entities with the feeling that when we had so classified them we had satisfied the needs of the patient. To be sure, such an arrival at a classification implies some understanding but the classification should not be an end in itself and we feel that psychiatry would be further advanced if we looked upon the disorders that we see in the patients as reactions on their part as human organisms to demands that have been made upon them. We should recognize that these are always individual reactions, the exact nature of which depends upon the fundamental capacity of the individual as well as on the demands that have been made on him. Psychiatry and the patients would be helped if we continued to try to understand everything possible about why a particular patient reacted in a certain way, what happened when his capacities for adjustment were overwhelmed, what can be found out about his ultimate capacity and what can be done about keeping him within it. What we call the dementia præcox reaction at the present time includes, of course, a wide variety of reactions, with individuals showing wide degrees of capacity or lack of it. For example, the reaction that is called simple dementia præcox of the hebephrenic type is in many respects quite different from the reaction known as the paranoid dementia præcox type and studies of physical constitution show also a rather wide difference in many respects in these groups.

It is possible that in the future it may be best to recast our types of classification and emphasize constitutional features with degrees of capacity and incapacity and classify psychiatric reactions somewhat according to such a scheme. In somewhat the same manner, it may eventually prove to be an advantage to classify emotional reactions which we now call the manic-depressive reactions, according to their type of constitutional reaction, rather than looking upon the many varieties of emotional reaction which are now placed

in this group as evidence of a disease entity, which the manic-depressive reactions probably are not. However we classify for statistical purposes these psychiatric disorders, may we again emphasize that it seems wise that they should be looked upon as individual reactions of human organisms and that the many factors bringing about these reactions should receive further study and constitute the trend of psychiatric research during the next 10 years or more.

It is perhaps unnecessary to say that we feel that dementia præcox or the manic-depressive reactions will not be found to be due to any one specific factor such as infection by a particular organism or by autointoxication or any other one thing that can be easily grasped and eradicated for the complete prevention and cure of these reactions. The reactions of normal persons have many determinants and there is no particular reason to think that the reaction which are looked upon as abnormal have any fewer determinants. As we have previously pointed out elsewhere, there is no particular reason for assuming that the belief of a Republican or a Democrat is due to any specific brain lesion or any specific brain disease, however much his opponent may think this to be true. Nor are what are called eccentricities or various mystic beliefs reasonably to be thought of as due to any one specific causative factor. Mental disease is relative and the person who today is looked upon as a case of dementia præcox might not have been so judged many years ago and perhaps would not be so judged in an entirely different environment. The complete understanding therefore, of these reactions in our psychiatric patients which we call abnormal, cannot be arrived at by any miracle or all-inclusive discovery. It is of course, a human tendency to seek an easy, simple solution of all that is unknown but we as psychiatrists and other persons who are interested in psychiatric problems should not be discouraged by an apparent lack of such complete understanding or be stampeded into feelings of inadequacy when the general public seems surprised that we have not solved all of the problems.

Psychiatry has made progress and will continue to make progress in the understanding and treatment of mental disorder and it is only to be expected that such progress may be slow and at times very laborious.

SOME PSYCHIATRIC ASPECTS OF MARIJUANA INTOXICATION

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Within recent years there has been an increasing use of the drug "marijuana," particularly among the criminal and "Bohemian" classes. In addition, one occasionally sees reports of its sale to children of high school age. However, since its users do not commonly enter psychiatric hospitals for treatment, there is a scarcity of literature about its effects upon the nervous system, although the active principle of the drug, cannabis indica, is well known.

The drug has been known since ancient times, and under various names. It is thought to have originated in Central Asia, but not to have developed its narcotic properties until its transfer to India.[1] Kingman,[2] in an interesting article in 1927, suggested that it was this drug which Marco Polo reported having seen used by the "King of the Hashishans" (Assassins) to stimulate his servants to carry out their crimes. It was from this that the name "hashish" was derived. The effects of the drug are also mentioned frequently in the "Arabian Nights" under various names.[3] It has been used by the Hindus in worship of the god, Shiva. Gautier, the novelist, and Baudelaire, the poet, used it frequently and have described their sensations while under its influence. Bragman[4] stated in 1925 that the drug was first used in this country in the nineteenth century, and expressed the belief that it did not cause mental illness. Physiologists and psychologists first used it for scientific purposes in the latter part of the nineteenth century, and descriptions of its effects have been written by Weir Mitchell and others, though usually it was studied as "cannabis indica."[6, 7, 8]

The drug is known properly as "cannabis indica," "cannabis sativa," or "cannabis americana." Its active principle is cannabinol, an alkaloid.[7] The plant may grow anywhere in this country in the wild state, but is cultivated legally only in Kentucky, where its fibers are used in the manufacture of hemp rope. It is a tall, erect herb, from three to eight feet high when wild, and four to

five feet high when cultivated. The leaves are narrow, lancet-shaped, and green in color.

The names of the drug are many. In India it is sold in three forms: "ganja," "bhang," and "charas." The first, a mixture of the stems, leaves and flowering tops, is smoked or eaten. The second, a mixture of dried leaves and seed capsules, is used to form a decoction which is drunk. The third, consisting of resinous material from the flowers, is the "hashish," and is smoked or eaten in pills. This form is the most potent.

The name, "marijuana" comes from a Latin-American word meaning any substance producing intoxication. In this country the drug is known to its users as "muggles," "reefers," "Indian hay," "the weed," "loco weed," "tea," "Mary Warner," and "goof butts," and is ordinarily used in the form of cigarettes.

In India, its importance is considered great, both in association with crime and as a causative factor in mental diseases. Dhunjibhoy states:[1] "I put this drug above alcohol, opium, and cocaine with regard to the causation of insanity." Bromberg[9] points out that there is legislation against its use in only 17 of the United States, and that it is not included in the Federal Narcotic Law. He says that its use is widespread in New York, and that prisoners disclosed its use frequently in routine psychiatric examinations, though few used it regularly. A recent newspaper article states that the police of New York City destroyed 170 tons of the plants within two months, often finding it growing in backyards and vacant lots, where it had been planted deliberately.

The danger of true addiction is rare, since there are no unpleasant after-effects, no withdrawal symptoms, and no development of tolerance. Drug addicts seldom use it, and it is usually taken at parties, few people using it regularly. Its chief antisocial effects arise from the release of aggressive or sexual drives in individual users. Of 361 prisoners diagnosed as psychopathic personalities, none had committed crimes while under its influence, and it was felt that the drug uncovered previously existing antisocial drives, rather than actually producing them.[9] Dhunjibhoy,[1] however, holds the view that it may sometimes be directly responsible, particularly for sexual crimes, since it is definitely an erotic stimulant.

The symptomatology of marijuana intoxication is rather characteristic, and in the more acute stage offers little difficulty in diagnosis. All observers, both in this country and in Europe and India, report that disturbance in the *perception of time and space* during intoxication is a typical response to the drug. The individual feels that minutes are hours, and space perception may be interfered with to such an extent that, like the case to be reported, the user may feel that he is small enough to get to the bottom of a glass of water, or else, may feel himself to be so large that he must use care not to step upon people who may be near him. In addition, where delusional trends are present, their sexual content is marked.

An acute intoxication is usually ushered in by a period of anxiety accompanied by vague fears lasting from 10 to 30 minutes after use, and accompanied by restlessness and hyperactivity. Calmness follows, then euphoria. The subject becomes talkative, appears to be elated, laughs in an uncontrollable and explosive manner for no apparent reason, and shows a rapid, flighty speech. Subjectively, the body feels light, and there is a sensation of mental brilliance. Sexual excitement is present, apparently because sexual objects in the immediate vicinity appear highly desirable. There are visual hallucinations characterized by flashes of light and color, faces and figures. About two hours after the use of the drug there is drowsiness followed by a dreamless sleep, and upon awakening there are no after-effects. The subject, during the period of intoxication, has had the feeling that time was very long.[9]

Recently the writer has had occasion to talk to several people who have used marijuana, all of them being apparently unstable persons. While all denied ever having smoked enough to experience hallucinations they commented on "a sense of exhilaration—like having had two or three drinks," but only one of them spoke of increase in sexual desire. A friend of the patient whose case is to be reported describes a "reefer party" which he attended at a time when he was neither drinking nor using the drug, and emphasized the hilarity and causeless laughter to be observed.

There are three different conditions under which the users of marijuana are seen by the psychiatrist: first, the state of acute intoxication; second, states which represent reactions to the fea-

tures of the first; and third, "toxic psychoses which usually seem to be the admixture of the toxic effects of the drug to a basic cyclothymic or schizophrenic reaction."[9] This last state is called "chronic" by Dhunjibhoy, and he says that a state of "dementia" may follow this—probably meaning the state of ultimate deterioration found in dementia præcox.

The state of acute intoxication is characterized by any or all of the following: "sensory symptoms, kinesthetic disturbances, changes in time perception, increase in motor activity, excitement, increase in rapidity of thought processes, confusion, disorientation, clouding of perception, elementary visual hallucinations, and manic-like behavior."[9] Recovery from such states usually occurs within two days.

The states which represent reactivity to the above features are varied. They may be characterized by hysterical anxiety, homosexual panic states, or fright reactions. The emotional or psychoneurotic reaction disappears when the drug has ceased to act, thus they would be unlikely to last more than a week. Bromberg reports two cases of this type, one of whom had used the cigarettes occasionally for two years, and the other having just indulged for the first time.

The third group, those in which there appears to be a toxic psychosis, plus a mixture of schizophrenic and cyclothymic reactions, is that with the least typical symptoms. It is frequently difficult to decide whether the functional psychosis was precipitated by the drug, or whether the use of the drug followed the development of the psychosis. The patient to be reported emphasizes this difficulty, for when the case was first presented the diagnoses suggested by the staff were variously catatonic dementia præcox, paranoid dementia præcox, and toxic psychosis due to drugs. In the second presentation, although the general impression was that the illness was a psychosis due to the drug, one observer suggested that it might be a manic attack, with the drug acting as a complicating factor. In the cases reported by Bromberg, the same difficulty in diagnosis appears to be present. Incidentally, he emphasizes the fact that the appearance of the psychosis seemed to be irrespective of the amount of drug used, or the length of time used. In his

cases, the psychoses persisted for from three weeks to several months, and two of the subjects did not recover.

Case Report

The following case report is intended to illustrate some of the peculiar features of such an illness, with its accompanying diagnostic difficulties. It will be given in sufficient detail to emphasize the patient's unusual personality, and to bring out some of the problems which underlay his trends.

A. B., a married man of 30, was admitted to the hospital in a confused, disoriented state.

Born in Europe, he was the illegitimate child of a young barmaid and a manufacturer who had risen to wealth through his own efforts. Later in life, the father appears to have had some sort of mental illness, of which there are no details. Shortly after his birth, the mother left the patient in the care of friends, and disappeared. He was raised by these people, and later adopted by them, apparently being given the same amount of attention as his foster-brother received. However, it is reported that his foster-mother reproached him frequently because his mother "was not a good woman," and when he misbehaved she reprimanded him by saying that he was like his mother.

He had the usual childhood diseases, and at nine, an appendectomy. He was a "lively, good-natured, playful, and well-behaved child." However, he had a rather quick temper, and was somewhat sensitive about his mother, often saying that if she had loved him she would never have left him.

He completed in Europe at 12 what corresponds to "high school" and then was apprenticed to a pharmacist for a few years. In addition, as he had shown great interest in music since childhood and been able to play the violin and piano at an early age, he was given training in music with the local opera company.

He was sexually precocious, and before the age of 10 a nursemaid frequently stimulated him sexually. At 14, he attempted to associate with prostitutes on at least one occasion.

His foster-father died when the patient was 14, and three years later he came to this country with his foster-mother, who was in

limited circumstances, financially. The patient attempted to support himself, but led a rather irregular life, and at 17 he was arrested for stealing an automobile and was sentenced to a reformatory. At first he was a stubborn prisoner and was kept in solitary confinement. Finally, he attracted the attention of the warden and a music teacher, who gave him a little training in both English and music. After serving a year he was "paroled and then pardoned." Given a recommendation regarding his musical ability he came to New York, and at 19 obtained work as a copyist with a music firm. Studying at night, and working during the day, he was promoted rapidly. At the age of 24, after a courtship of three years, he married. Feeling that he could not afford a child, anticonceptual measures were used until 1933. He then expressed a desire for children, and four months before his admission to the hospital his wife gave birth to a daughter.

For three years before his illness the patient had been working under considerable pressure, and had had no vacation. Occasionally he complained vaguely of "office politics," and for a short period he went to work for another firm, but gave this up to accept a better position with the original one.

He rarely used alcohol, since even small amounts caused him to become nauseated. A year before admission he started using marijuana, using two to three cigarettes nightly, usually at parties, and often taking a few puffs at times during the day. These seemed to cause considerable sexual stimulation, and he would frequently leave his office for a few hours to visit prostitutes. His wife asked him to give up the use of the drug, which he promised to do, but did not keep the promise. According to reliable informants he kept up the use of drug, as well as the extramarital affairs, until the onset of the present illness.

His personality was a somewhat unusual one. Although intelligent and capable, he had a definite dislike for formal training, and disliked schools. He was a poor manager, and his wife handled all of the bills. Usually active and energetic, his interests were rarely well-sustained. He was sociable, friendly, tactful, and well-liked by those who knew him, yet he was somewhat suspicious, often complaining of "office politics." He was adaptable, and though pri-

marily interested in music, appeared to have a normal interest in the other things about him. He was frank, unburdened easily, somewhat egotistical, liked to be a leader, but had many friends. Usually optimistic, he was sometimes worried over trivial things, and occasionally given to outbursts of anger. He appears to have been well adapted to marriage, though there were extramarital affairs for the year previous to his hospitalization, and he is reported to have requested fellatio with his wife during that time. At times he expressed a feeling of inferiority, complained of gastro-intestinal disturbances, and seemed rather sensitive. (His feeling for music was marked, and he has vomited while on the way to hear the music of Wagner.)

A year before admission, for a period of about two weeks, he seemed a little "queer," speaking of wishing to separate from his wife. When she offered to go away for six months this wish disappeared. He then seemed well until two months before admission at which time he began to stay out late, rather frequently explaining this by saying he was "listening to musical arrangements." It is known that he attended "marijuana parties" during this time, and on at least one occasion visited a house where sexual perversions were practiced. Six weeks before admission he went on a trip to the World's Fair at Chicago, accompanied by a somewhat effeminate male friend, whose expenses he paid. They smoked a great deal of marijuana on the trip, and he is said to have been unusually talkative at that time. He also expressed fears that a woman with whom he had been involved would injure his wife and child. While in Chicago he bought expensive gifts for his friends, used morphine once or twice to see what its effect was, and had intercourse with a prostitute. On his return two weeks later he was very talkative but quite coherent. He "confessed" to his wife many affairs with women, and saw a doctor, fearing that he had syphilis. Five days later he said that his mind was "in a fog." Two days later he seemed apprehensive, was afraid to sleep because he feared "sleeping sickness." He shaved his mustache because "people were laughing at him." He went out for a while one night, behaved queerly while with some friends, and when they visited him a few hours later he could not remember what he had said to them.

The next morning at 5:30 he got up and took his two dogs down to the garden. Later he spoke of reforming the world; said he was Jesus Christ; wanted to help the country by giving it back to the Indians. He said that machine guns were around the house, and spoke of wanting to take charge of things in the office.

He was then admitted to a psychiatric hospital, where he seemed confused and disoriented. He also appeared depressed, misidentified people, and was manneristic. The confusion was most marked at night. Three weeks later he was transferred to another mental hospital.

Physically, there were on admission to this latter hospital no findings of significance, except for enlarged tonsils.

The mental examination showed him to be preoccupied, somewhat seclusive, but neat and clean. Later he lay rigidly in bed, again would rise and play the piano, playing the same tune over and over. His speech was incoherent and disjointed, and at times he left sentences unfinished. Mood was one of apathy; he said that he was both happy and sad at different times. He said that he was worried about the friend with whom he took the trip to Chicago, adding: "He was a very good friend. He changed and became effeminate with me, if it was him. I thought we would be happy, my wife and I, but I went out with other women." He said he had delusions; people read his thoughts, they talked about his wife, there were dictaphones checking up on him, he had a secret power over others, things seemed real to him but other people seemed to be dreaming, strange things had happened to his body, his own voice came out of his stomach, he had had thoughts of being Christ, but said this might be a delusion. There was disorientation as to time, though he knew where he was. Remote memory was satisfactory, but recent memory was poor. Retention and recall were only fair. He gave an unusual answer when asked about the test story, saying it had never happened to him so he could not tell about it. Attention tests fair. Knowledge appeared to be limited, and insight and judgment were poor.

During his first days in the second hospital he was rather cooperative, but slow in movement. Later he misidentified other patients, postured, or sat about nude. He masturbated openly. Al-

though he denied hallucinations he said that those about him were referring to him in their conversation. On one occasion he tried to burn his hands in the fire, and again tried to burn himself with a cigarette, saying he wished to see if he were "tough enough to stand it." Three weeks after admission he made an impulsive attempt to eat a light bulb which he had broken. At this time he was amenable to suggestions, pleasant in manner, would talk quietly to himself, and occasionally appeared to be hallucinating. Eight weeks after admission he struck an attendant, and said that he was tired of being ordered about. There was considerable incoherent talk of sexual matters. He talked freely of previous sexual experiences. Also he said that he had orders from the stars while in the Planetarium in Chicago. He continued to be rather restless, slept poorly, and often shouted and whistled at night. Nine weeks after admission he shouted, beat his mouth with his hands until his lips bled, talked incoherently, gave evidences of coprophilia, and showed posturing. A week later he began gaining weight, seemed calmer, but still talked rather incoherently. The following is a sample of his speech at that time: "It's sex that makes the world go round. It has to do with animals. I analyze everything. I study the clouds. I hear things." At the same time he was able to recount freely previous events of his life, described a "dream" induced by marijuana in which he said he felt like a baby, and had sunk to the bottom of a glass of water, and added that he had recently had a similar sensation. About three months after admission he had improved markedly, though still saying that he heard unusual sounds, which he misinterpreted. At this time he said that he had felt somewhat the same as he had before when using marijuana, experiencing visual hallucinations and illusions of color. Improvement continued, and finally he became able to give a retrospective account of some of his delusions and hallucinations. He said, in part: "I seemed to change in size. I thought that I was very small —once I thought I was death itself clattering my teeth—then I thought I was Tarzan, calling the animals. I thought I was changing into a woman. I thought I was H. G. Wells' invisible man. I could not distinguish between nurses, doctors and patients." Tests of his sensorium now showed him to have a rather patchy amnesia

for parts of the acute state. He said about this: "I never believed the date. It seemed like years to me." His convalescence continued uneventfully, and five months after admission he was discharged as recovered. Ten months after his discharge from the hospital reports indicated that he had remained well, and had not returned to the use of the drug.

Comment

This patient was of unstable make-up, but one would hesitate to say that he has a true psychopathic personality. Despite his instability, and the many unfortunate factors in his life history, he succeded in making a satisfactory adjustment to his environment, after a rather stormy adolescence.

It was not until his wife became pregnant that he began the use of marijuana. For a time he used the drug moderately, experiencing as time went on some of the milder effects of marijuana intoxication. Eventually there was some change in his personality patterns, especially in his objective relationships. This was shown in his unfaithfulness to his wife, and the type of women with whom he associated. On one or two occasions he showed interest in effeminate men. It was while on a trip with a male friend, before admission, that he smoked a great deal of marijuana. Mild delusions of reference appeared, which were fleeting in character, and transitory feelings of confusion also developed. A few days before the onset of his illness he was still using marijuana, and was now more certain that people were laughing at him, and talking about him. He also had some hypochondriacal ideas. For a time he would be clear, then confused, especially at night. Eventually he developed some ideas of grandeur, and on one occasion identified himself with Christ.

After admission to the hospital evidence of a deep regression appeared, with a number of bizarre ideas and hallucinations. The clinical picture then appeared like a case of schizophrenia, but evidence of the organic nature of the process was indicated by his partial disorientation and poor recent memory, the disturbance in sensorium being more marked at night. Later, in retrospect, he said that during the acute phase of his illness time seemed to stand

still. He felt that he had become very small, like a tiny baby, and he actually mentioned that he believed at one time that he had sunk to the bottom of a glass of water. Such sensations occurred at intervals during his illness. He also believed that his wife had changed in shape. He recalled that his mood varied from periods of ecstasy and well-being to periods of depression with feelings of frustration and inadequacy.

Psychologically, one might say that in his regression his homosexuality was projected in the form of his paranoid delusional ideas. Evidence of deeper regression was, however, shown by his coprophilia and other infantile manifestations.

Considering this individual's personality, the onset of his illness and its acute manifestations, including the feelings which he had that time seemed to pass slowly (a few days seeming like a few years), and his ideas relating to changes in his own size and the objects in his environment, as well as the reference to color phenomena, it is evident that the illness was due to marijuana intoxication. At the height of the illness the clinical picture could be considered schizophrenic but, with the etiological factors so clearly defined, and the rather typical involvement of time and space conceptions, this diagnosis could be ruled out. The fact that he has continued well since he left the hospital, approximately a year ago, confirms this.

Conclusions

1. A review of some of the literature on marijuana intoxication has been made.

2. A case of mental illness, due to the use of marijuana and showing marked schizophrenic coloring, is presented.

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THE COMPLEMENT FIXATION TEST FOR SYPHILIS APPLIED TO OXALATED BLOOD

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Venipuncture, for the purpose of securing blood for laboratory tests, is not only a painful but, in certain psychiatric cases, a very emotionally disturbing procedure. In mental hospitals it should be reduced to as low a minimum as is consistent with the adequate scientific investigation of patients.

The writer has been very favorably impressed by the work of Osgood and his associates, of the University of Oregon Medical School, out of which grew their "Uniform System of Hematologic Methods for Use with Oxalated Venous Blood."* They recommend oxalated blood as suitable for the following tests: hemoglobin estimation, red cell count, platelet count, red cell volume, color index, volume index, saturation index, icterus index, Van den Bergh test, white cell count, smear for differential count, peroxidase test, fragility test and sedimentation rate determination. Oxalated blood is also commonly used for the quantitative determination of blood sugar, nonprotein nitrogen, uric acid nitrogen, urea nitrogen, creatinine, etc. Thus one sample of blood can be made to suffice for any one or even a large number of the above determinations at a great saving of time to the clinician, whose duty it is to secure the samples, as well as to spare the patient the distress occasioned by repeated bleedings.

The writer, in following out this plan in the laboratory of the Binghamton State Hospital, has since July 1, 1932, applied still another test to oxalated blood, namely, the complement fixation test for syphilis. It is the practice on the receiving ward to secure from each newly-admitted patient a liberal sample of blood by venipuncture in a tube containing a few crystals of potassium oxalate, taking care to secure thorough mixing before clotting begins. This blood tube is properly labeled with the name of the patient and a list of the tests desired by the clinician on the particular specimen. Upon receipt of such samples at the laboratory the

*A Uniform System of Hematologic Methods for Use with Oxalated Venous Blood," by Osgood, Haskins and Trotman. Jour. Lab. and Clin. Med., Vol. XVI, No. 5, Feb., 1931.

tests are promptly performed and the remainder of the specimens set aside for the complement fixation test for syphilis.

The use of plasma from oxalated blood, for this purpose, requires but one additional step as compared with the usual practice of employing serum from clotted blood. After the plasma has been inactivated at 55° C. for 30 minutes it becomes necessary to again centrifugalize the specimen to remove the precipitated fibrinogen in order that a perfectly clear serum be made available for the complement fixation technique. In the beginning of this study a series of comparative tests was run between oxalated and clotted blood from the same cases, to determine the reliability of this method, and the results were found to be identical.

It has been observed, however, that oxalated specimens show a tendency to become anticomplementary on standing over night so it is advisable to delay inactivation until just before the tests are to be performed, or to repeat the inactivation. When this precaution is observed anticomplementary results are an extreme rarity. Over 3,000 tests have been performed with entirely satisfactory results.

Thus from a single blood sample practically all desired hematologic data are obtained.

MARITAL STATUS IN RELATION TO THE PREVALENCE OF MENTAL DISEASE

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In the course of the statistical study of phenomena associated with mental disease, it was observed at least a century ago that the incidence of these disorders varied with marital status. It was noted that married persons had lower rates of mental disease than single individuals.[1] This observation was demonstrated on a large scale, when the enumeration of the insane in institutions in the United States in 1910 showed that although single males comprised 38.7 per cent of the general population, they constituted 48.4 per cent of the admissions to the hospitals for the insane. The married population, on the other hand, represented 55.8 per cent of the general population, but only 39.2 per cent of the admissions.[2] Females showed similar contrasts. The census of patients in hospitals for mental disease in the United States in 1923 failed to confirm this tendency, however, but showed that the single had a rate of first admissions of 47.4 per 100,000 unmarried population in 1922, compared with a rate of 71.1 among the married.[3] The report suggests that this may be the result of age selection, since the single are younger than the married, and the rate of first admissions increases with age.[4]

None of the earlier studies considered the relation of marital status to mental disease with the detail that the subject seems to warrant. It is evident, in the first place, that age composition must be given due consideration, and that the marital groups should therefore be contrasted from the viewpoint of standardized rates of first admissions. In the second place, it is desirable to include an analysis of the more important groups of psychoses. In the following study, therefore, rates of first admissions are provided according to marital status, age and psychoses among 28,359 first admissions to all hospitals for mental disease in New York State, aged 15 years and over, during the three fiscal years ended June 30, 1931. Of this total 10,473, or 36.9 per cent, were single; 12,817, or 45.2 per cent, married; 4,387, or 15.5 per cent, widowed; and 443, or 1.6

TABLE 1. FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1929-1931, AMONG THE SINGLE POPULATION*

Psychoses	Number of first admissions			Per cent of total first admissions			Average annual rate per 100,000 single population*		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Traumatic	69	6	75	1.0	0.2	0.7	1.3	0.2	0.8
Senile	178	264	442	2.6	7.2	4.2	3.5	6.2	4.7
With cerebral arteriosclerosis	417	285	702	6.1	7.7	6.7	8.1	6.7	7.5
General paresis	585	53	638	8.6	1.4	6.1	11.3	1.2	6.8
With cerebral syphilis	60	13	73	0.9	0.4	0.7	1.2	0.3	0.8
With other brain or nervous diseases	114	52	166	1.7	1.4	1.6	2.2	1.2	1.8
Alcoholic	525	22	547	7.7	0.6	5.2	10.2	0.5	5.8
With other somatic diseases	67	73	140	1.0	2.0	1.3	1.3	1.7	1.5
Manic-depressive	653	683	1,336	9.6	18.5	12.8	12.7	16.1	14.2
Involution melancholia	53	106	159	0.8	2.9	1.5	1.0	2.5	1.7
Dementia præcox	2,973	1,450	4,423	43.8	39.3	42.2	57.7	34.1	47.0
Paranoia or paranoic conditions	41	54	95	0.6	1.5	0.9	0.8	1.3	1.0
Epileptic psychoses	214	112	326	3.2	3.0	3.1	4.2	2.6	3.4
Psychoneuroses and neuroses	75	103	178	1.1	2.8	1.7	1.5	2.4	1.9
With psychopathic personality	235	120	355	3.5	3.3	3.4	4.6	2.8	3.8
With mental deficiency	325	207	532	4.8	5.6	5.1	6.3	4.9	5.7
All other psychoses	24	12	36	0.4	0.3	0.3	0.5	0.3	0.4
Undiagnosed psychoses	78	36	114	1.1	1.0	1.1	1.5	0.8	1.2
Without psychosis	99	37	136	1.5	1.0	1.3	1.9	0.9	1.4
Total	6,785	3,688	10,473	100.0	100.0	100.0	131.6	86.7	111.3

*Aged 15 years and over.

per cent, divorced. The marital status was not determined in 239 cases. No adjustment has been made in the following rates for the unknown total, as the latter does not affect the rates in a significant manner.

Single

Of the 10,473 single first admissions to all institutions for mental disease in New York State during 1929-1931, aged 15 years and over, 6,785, or 64.8 per cent, were males, and 3,688, or 35.2 per cent, were females. There was an average annual rate of 111.3 first admissions per 100,000 single population, aged 15 years and over. Males and females had rates of 131.6 and 86.7, respectively.

The first admissions are classified according to psychoses in Table 1.

Of the 10,473 single first admissions, 4,423 were cases of dementia præcox, representing 42.2 per cent of the total, and providing an average annual rate of 47.0 per 100,000 single population. No other group of psychoses was of numerical significance. The preponderance of dementia præcox resulted from the relatively low age of unmarried individuals. The manic-depressive psychoses constituted the second largest category, including 12.8 per cent of the total first admissions, and giving a rate per 100,000 single population of 14.2. Psychoses with cerebral arteriosclerosis, general paresis and alcoholic psychoses followed in the order named. The low frequencies of the latter groups are accounted for primarily by the age composition of the single population of New York State.

Sex differences appear as follows: General paresis and the alcoholic psychoses were more frequent among males, being exceeded only by dementia præcox and manic-depressive psychoses. Females, on the other hand, had greater frequencies of senile psychoses, and manic-depressive psychoses.

Married

First admissions to all institutions for mental disease in New York State in 1929-1931 included 12,817 married individuals, aged 15 years and over, of whom 6,848, or 53.4 per cent, were males and 5,969, or 46.6 per cent, females. The latter thus represented a much higher percentage of first admissions than in the case of the

TABLE 2. FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1929-1931, AMONG THE MARRIED POPULATION*

Psychoses	Number of first admissions			Per cent of total first admissions			Average annual rate per 100,000 married population*		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Traumatic	135	21	156	2.0	0.4	1.2	1.6	0.3	0.9
Senile	412	260	672	6.0	4.4	5.2	5.0	3.2	4.1
With cerebral arteriosclerosis	1,138	579	1,717	16.6	9.7	13.4	13.7	7.0	10.4
General paresis	1,478	397	1,875	21.6	6.7	14.6	17.8	4.8	11.4
With cerebral syphilis	115	52	167	1.7	0.9	1.3	1.4	0.6	1.0
With other brain or nervous diseases	93	74	167	1.4	1.2	1.3	1.1	0.9	1.0
Alcoholic	723	196	919	10.6	3.3	7.2	8.7	2.4	5.6
With other somatic diseases	110	246	356	1.6	4.1	2.8	1.3	3.0	2.2
Manic-depressive	694	1,313	2,007	10.1	22.0	15.7	8.4	16.0	12.2
Involution melancholia	191	321	512	2.8	5.4	4.0	2.3	3.9	3.1
Dementia præcox	1,024	1,741	2,765	15.0	29.2	21.6	12.4	21.2	16.8
Paranoia or paranoic conditions	72	52	124	1.1	0.9	1.0	0.9	0.6	0.8
Epileptic psychoses	73	100	173	1.1	1.7	1.3	0.9	1.2	1.0
Psychoneuroses and neuroses	105	171	276	1.5	2.9	2.2	1.3	2.1	1.7
With psychopathic personality	174	130	304	2.5	2.2	2.4	2.1	1.6	1.8
With mental deficiency	77	120	197	1.1	2.0	1.5	0.9	1.5	1.2
All other psychoses	53	53	106	0.8	0.9	0.8	0.6	0.6	0.6
Undiagnosed psychoses	93	98	191	1.4	1.6	1.5	1.1	1.2	1.2
Without psychosis	88	45	133	1.3	0.8	1.0	1.1	0.5	0.8
Total	6,848	5,969	12,817	100.0	100.0	100.0	82.6	72.6	77.7

*Aged 15 years and over.

unmarried population. The average annual rate of first admissions was 77.7 per 100,000 married population aged 15 years and over. Males and females had rates of 82.6 and 72.6, respectively.

The married first admissions are classified according to psychoses in Table 2.

Of the 12,817 married first admissions, 2,765, or 21.6 per cent, were cases of dementia præcox, providing an average annual rate of 16.8. This is less than half the corresponding frequency among the unmarried, and is a consequence of the higher ages of the married population. Manic-depressive psychoses constituted the second largest category, followed closely by general paresis and psychoses with cerebral arteriosclerosis. The high rank of the latter groups is, in part, a consequence of the higher age levels of the married population.

There were the usual sex differences in the distribution of the psychoses. Psychoses with cerebral arteriosclerosis, general paresis, and the alcoholic psychoses were more frequent among the males. The manic-depressive psychoses were more prevalent among the females. It is interesting to note, however, that the senile psychoses had a greater frequency among married males, and dementia præcox a greater frequency among married females. These are contrary to the usual results, for which no obvious reasons are apparent.

Widowed

The widowed population of the State of New York totaled 720,140 on April 1, 1930. This population contributed 4,387 first admissions to all institutions for mental disease in New York in 1929-1931, of whom 1,742, or 39.7 per cent, were males and 2,645, or 60.3 per cent, females. The great excess of the females is, in large part, the consequence of the greater longevity enjoyed by females in general. The widowed population had an average annual rate of first admissions of 203.1 per 100,000 corresponding population aged 15 years and over. Males and females had rates of 294.5 and 168.6, respectively.

The first admissions among the widowed population are classified according to psychoses in Table 3.

TABLE 3. FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1929-1931, AMONG THE WIDOWED POPULATION*

Psychoses	Number of first admissions			Per cent of total first admissions			Average annual rate per 100,000 widowed population*		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Traumatic	31	5	36	1.8	0.2	0.8	5.2	0.3	1.7
Senile	423	902	1,325	24.3	34.1	30.2	71.5	57.5	61.3
With cerebral arteriosclerosis	612	819	1,431	35.1	31.0	32.6	103.5	52.2	66.2
General paresis	178	108	286	10.2	4.1	6.5	30.1	6.9	13.2
With cerebral syphilis	25	24	49	1.4	0.9	1.1	4.2	1.5	2.3
With other brain or nervous diseases	8	10	18	0.5	0.4	0.4	1.4	0.6	0.8
Alcoholic	149	48	197	8.6	1.8	4.5	25.2	3.1	9.1
With other somatic diseases	30	47	77	1.7	1.8	1.8	5.1	3.0	3.6
Manic-depressive	76	178	254	4.4	6.7	5.8	12.8	11.3	11.8
Involution melancholia	25	97	122	1.4	3.7	2.8	4.2	6.2	5.6
Dementia præcox	85	249	334	4.9	9.4	7.6	14.4	15.9	15.5
Paranoia or paranoic conditions	9	31	40	0.5	1.2	0.9	1.5	2.0	1.9
Epileptic psychoses	10	18	28	0.6	0.7	0.6	1.7	1.1	1.3
Psychoneuroses and neuroses	6	19	25	0.3	0.7	0.6	1.0	1.2	1.2
With psychopathic personality	20	28	48	1.1	1.1	1.1	3.4	1.8	2.2
With mental deficiency	2	20	22	0.1	0.8	0.5	0.3	1.3	1.0
All other psychoses	14	14	28	0.8	0.5	0.6	2.4	0.9	1.3
Undiagnosed psychoses	27	19	46	1.5	0.7	1.0	4.6	1.2	2.2
Without psychosis	12	9	21	0.7	0.3	0.5	2.0	0.6	1.0
Total	1,742	2,645	4,387	100.0	100.0	100.0	294.5	168.6	203.1

*Aged 15 years and over.

Among the widowed first admissions, there were but two groups of psychoses of numerical significance. The senile psychoses included 1,325 first admissions, or 30.2 per cent of the total, giving a rate of 61.3. Psychoses with cerebral arteriosclerosis included 32.6 per cent of the total, and represented a rate of 66.2. The next largest group, dementia præcox, included but 7.6 per cent of the total first admissions, and gave a rate of only 15.5. This distribution was a direct consequence of the age composition of the widowed population. Since the latter are of a generally advanced age, senile and arteriosclerotic disorders would naturally predominate. Examination of the sex distribution shows that the males had, as usual, markedly higher rates of psychoses with cerebral arteriosclerosis, general paresis and alcoholic psychoses. It is unusual, however, to find that the males also had a higher rate of senile psychoses, and that they had a slightly higher rate of manic-depressive psychoses.

Divorced

The divorced population of the State of New York contributed 443 first admissions to all institutions for mental disease during 1929-1931, of whom 219, or 49.4 per cent, were males and 224, or 50.6 per cent, females. There was an average annual rate of 280.1 first admissions per 100,000 divorced population aged 15 years and over. Males and females had rates of 330.1 and 244.0, respectively.

The 443 first admissions are classified according to psychoses in Table 4.

Dementia præcox was the leading category, including 26.4 per cent of the first admissions and providing a rate of 74.0. It is a significant fact that general paresis was second, with 18.1 per cent, and a rate of 50.6. This disease, in fact, ranks first among divorced males, and is an indication of the disordered lives that are characteristic of many divorced persons. Manic-depressive psychoses and psychoses with cerebral arteriosclerosis followed in the order named. The alcoholic psychoses with fifth, with 6.1 per cent, and a rate of 17.1. These were low compared with the preceding psychoses, but they were of marked significance in contrast with the other marital groups. This, too, is indicative of the disordered and irregular lives of many divorced persons.

TABLE 4. FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1929-1931, AMONG THE DIVORCED POPULATION*

Psychoses	Number of first admissions			Per cent of total first admissions			Average annual rate per 100,000 divorced population*		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Traumatic	6	1	7	2.7	0.4	1.6	9.0	1.1	4.4
Senile	6	9	15	2.7	4.0	3.4	9.0	9.8	9.5
With cerebral arteriosclerosis	23	14	37	10.5	6.2	8.4	34.7	15.3	23.4
General paresis	54	26	80	24.7	11.6	18.1	81.4	28.3	50.6
With cerebral syphilis	4	2	6	1.8	0.9	1.4	6.0	2.2	3.8
With other brain or nervous diseases	5	2	7	2.3	0.9	1.6	7.5	2.2	4.4
Alcoholic	21	6	27	9.6	2.7	6.1	31.7	6.5	17.1
With other somatic diseases	5	2	7	2.3	0.9	1.6	7.5	2.2	4.4
Manic-depressive	24	42	66	11.0	18.7	14.9	36.2	45.8	41.7
Involution melancholia	3	2	5	1.4	0.9	1.1	4.5	2.2	3.2
Dementia præcox	41	76	117	18.7	33.9	26.4	61.8	82.8	74.0
Paranoia or paranoic conditions	2	10	12	0.9	4.5	2.7	3.0	10.9	7.6
Epileptic psychoses	2	6	8	0.9	2.7	1.8	3.0	6.5	5.1
Psychoneuroses and neuroses	..	3	3	..	1.3	0.7	..	3.3	1.9
With psychopathic personality	11	12	23	5.0	5.4	5.2	16.6	13.1	14.5
With mental deficiency	4	5	9	1.8	2.2	2.0	6.0	5.4	5.7
All other psychoses	1	2	3	0.5	0.9	0.7	1.5	2.2	1.9
Undiagnosed psychoses	3	2	5	1.4	0.9	1.1	4.5	2.2	3.2
Without psychosis	4	2	6	1.8	0.9	1.4	6.0	2.2	3.8
Total	219	224	443	100.0	100.0	100.0	330.1	244.0	280.1

*Aged 15 years and over.

Sex differences were apparent in the markedly higher rates among males of psychoses with cerebral arteriosclerosis, general paresis, and alcoholic psychoses. Females, on the other hand, had higher rates of manic-depressive psychoses and dementia præcox. The latter difference is noteworthy.

In the following sections we shall compare the several marital groups with each other, with respect to the incidence of the more important groups of psychoses. But before doing so, it is necessary to consider the factor of age. In Table 5, rates of first admissions are shown by sex and age for all psychoses combined, among each of the marital groups.

TABLE 5. AVERAGE ANNUAL RATE OF FIRST ADMISSIONS PER 100,000 POPULATION TO ALL INSTITUTIONS FOR MENTAL DISEASE IN NEW YORK STATE, 1929-1931, BY AGE, SEX AND MARITAL STATUS

Age (years)	Males				Females			
	Single	Married	Widowed	Divorced	Single	Married	Widowed	Divorced
15-24	66.2	28.1	101.9	74.6	43.8	48.1	57.6	110.4
25-34	160.5	46.8	149.0	253.1	107.1	60.8	96.4	198.7
35-44	248.4	77.3	224.7	307.4	155.4	76.3	117.5	208.0
45-54	268.5	89.6	252.7	318.7	166.9	81.4	117.9	226.1
55-64	306.1	106.9	244.9	371.4	197.7	80.1	128.8	316.4
65-74	445.4	170.4	310.2	603.9	267.0	115.2	193.1	1,371.9
75 and over	646.2	294.9	455.3	1,550.4	515.4	257.2	337.4	2,589.0

With but one minor exception, the rates rose among males from minima at 15 to 24 years to maxima at 75 years and over. Among the single the rates rose from 66.2 to 646.2. Among the widowed they rose from 101.9 to 455.3. The divorced had a lower rate than the widowed at 15 to 24 years, a result probably accidental. Their rates exceeded those of any other group thereafter, rising to a maximum of 1,550.4 at 75 years and over. The married population had lower rates of first admissions than any of the others in each age group, the rates growing from 28.1 to 294.9. At 25 to 34 years the rates of the single population exceeded that of the married in the ratio of 3.4 to 1. Thereafter the rates of the single population, though always in excess, grew relatively less

rapidly, so that the ratios of the rates of the single to those of the married decreased steadily to a minimum of 2.2 to 1 at 75 years and over. The rates of the widowed were similarly in excess of those of the married, the ratio of the corresponding rates decreasing from 3.6 to 1 at 15 to 24 years, to 1.5 to 1 at 75 years and over. The ratios provided by the divorced group showed a generally similar trend to the preceding, though the ratios were higher. The ratio of the rate of the divorced to that of the married rose from 2.7 to 1 at 15 to 24 years, to 5.4 to 1 at 25 to 34 years. The ratio declined thereafter to a minimum of 3.5 to 1 at 65 to 74 years. The high ratio at 75 years and over was probably due to an accidental fluctuation in the rates.

Among females the rates rose similarly from minima at 15 to 24 years to maxima at 75 years and over. In general, females had lower rates than males, and the married had lower rates than the other groups. Among the married the rates grew from a minimum of 48.1 to a maximum of 257.2. The ratios of the rates of the married to those of the other groups showed trends differing from those obtained in the case of the males. The married had a slightly higher rate than the single at 15 to 24 years. The rates of single females then grew more rapidly, until they were in excess in the ratio of 2.5 to 1 at 55 to 64 years. Thereafter the ratios decreased. The rates of the widowed were in marked excess of those of the married, though no definite trend in the ratios is apparent between 25 and 74 years. The divorced have far higher rates than any of the other groups. Their rates grew very rapidly with age, exceeding those of the married group in ratios of 11.9 to 1 and 10.1 to 1 at 65 to 74 years and 75 years and over, respectively.

The preceding comparisons must be borne in mind in contrasting the several marital groups with each other. Since the incidence of mental disease increases with advancing age, those groups which are concentrated at relatively low ages will be favored in comparison with those of advanced ages. That such differences exist is evident from a consideration of Table 6, which gives certain age constants for each of the marital groups in New York State.

TABLE 6. AGE CONSTANTS, IN YEARS, OF MALES AND FEMALES IN NEW YORK STATE, APRIL 1, 1930, AGED 15 YEARS AND OVER, ACCORDING TO MARITAL STATUS

Marital status	First quartile		Second quartile		Third quartile	
	Males	Females	Males	Females	Males	Females
Single	19.1	18.5	23.7	22.9	32.0	32.4
Married	33.8	32.8	42.0	38.4	52.3	48.5
Widowed	51.5	50.3	62.7	60.9	72.0	70.0
Divorced	35.5	31.5	43.0	38.4	52.3	47.1

As we would naturally anticipate, the unmarried were clearly younger than the married groups, and the widowed were older than the married. There were no significant differences between the divorced and the married.

In comparing rates of first admissions among the several marital groups, it is therefore necessary to adjust for the age difference. In the following discussion, we shall limit ourselves to standardized rates of first admissions. The populations adopted as standards are the following: In the case of all psychoses, general paresis, manic-depressive psychoses and dementia præcox, the population of New York State aged 15 years and over on April 1, 1930, was taken as the standard. In the case of psychoses with cerebral arteriosclerosis, the standard was the population aged 45 years and over. In connection with the alcoholic psychoses, the standard was the population aged 25 years and over.

ALL PSYCHOSES

TABLE 7. STANDARDIZED AVERAGE ANNUAL RATES OF FIRST ADMISSIONS TO ALL INSTITUTIONS FOR MENTAL DISEASE IN NEW YORK STATE, 1929-1931, CLASSIFIED ACCORDING TO MARITAL STATUS*

	Males	Females	Total
Single	211.2± 2.4	135.9± 2.1	174.0± 1.6
Married	71.9± 1.1	72.3± 1.1	72.4± 0.8
Widowed	193.3± 6.7	107.4± 3.1	150.7± 3.1
Divorced	284.6±24.2	294.1±20.9	296.8±16.0

*Population of New York State aged 15 years and over on April 1, 1930, taken as standard.

The married population had the lowest standardized rate of first admissions, namely 72.4 per 100,000 population aged 15 years and over. The divorced population had the highest rate, 296.8, which exceeded that of the married population in the ratio of 4.1 to 1. Single individuals had the second highest rate, which exceeded that of the married group in the ratio of 2.4 to 1. The widowed population also had a higher rate than the married, their ratio being 2.1 to 1. The relative orders are the same with respect to each sex. The ratios of the married rate to those of the single and widowed are greater, however, among the males than among the females.

Psychoses with Cerebral Arteriosclerosis

Table 8. Standardized Average Annual Rates of First Admissions with Psychoses with Cerebral Arteriosclerosis to All Institutions for Mental Disease in New York State, 1929-1931, Classified According to Marital Status*

	Males	Females	Total
Single	88.2± 4.8	49.6± 3.6	70.4± 3.0
Married	36.4± 1.2	25.9± 1.2	32.0± 0.8
Widowed	74.6± 4.5	42.5± 2.1	59.6± 2.1
Divorced	109.4±22.7	87.9±21.0	102.8±15.8

*Population of New York State aged 45 years and over on April 1, 1930, taken as standard.

The lowest standardized rate, 32.0, occurred among the married, the highest, 102.8, among the divorced, the latter rate being in excess in the ratio of 3.2 to 1. The widowed and single were intermediate, with rates of 59.6 and 70.4, respectively. The relative orders were similar among males and females. Among the former, however, the ratio of the maximum and minimum rates was 3.0 to 1, compared to a ratio of 3.4 to 1 among females.

General Paresis

Table 9. Standardized Average Annual Rates of First Admissions with General Paresis to All Institutions for Mental Disease in New York State, 1929-1931, Classified According to Marital Status*

	Males	Females	Total
Single	25.8± 1.9	1.9± 0.8	13.8± 0.3
Married	11.7± 0.4	4.1± 0.3	7.9± 0.3
Widowed	32.6± 2.7	8.7± 0.9	20.5± 0.4
Divorced	50.4±10.2	21.7± 5.7	35.7± 5.6

*Population of New York State aged 15 years and over on April 1, 1930, taken as standard.

The married population had the lowest standardized rate of first admissions with general paresis, 7.9. The divorced population had the highest rate, 35.7, the latter exceeding the minimum rate in the ratio of 4.5 to 1. The widowed, too, had a surprisingly high rate of 20.5, which exceeded that of the married in the ratio of 2.6 to 1. The unmarried population had a rate of only 13.8. This distribution, however, differs significantly with respect to sex. Thus among females, the single group had a significantly lower rate than any of the other groups. The married population had a rate of 4.1, the widowed 8.7, and the divorced 21.7. The maximum and minimum rates were in the ratio of 11.4 to 1. Among the males the relative disparity in rates was much smaller. Married males had the minimum rate of 11.7, divorced males the maximum, 50.4, the latter being in excess in the ratio of 4.3 to 1. Widowers had the surprisingly high rate of 32.6. Single males had a rate of 25.8, which exceeded that of the married in the ratio of 2.2 to 1.

Alcoholic Psychoses

Table 10. Standardized Average Annual Rates of First Admissions with Alcoholic Psychoses to All Institutions for Mental Disease in New York State, 1929-1931, Classified According to Marital Status*

	Males	Females	Total
Single	29.2± 1.3	1.4± 0.3	15.4± 0.7
Married	8.6± 0.4	2.5± 0.2	5.5± 0.2
Widowed	33.5± 2.8	4.9± 0.7	19.3± 1.1
Divorced	29.4± 7.9	5.1± 2.8	17.2± 3.9

*Population of New York State aged 25 years and over on April 1, 1930, taken as standard.

The widowed had the maximum rate, 19.3, followed by the divorced with a rate of 17.2, and the single with a rate of 15.4. These three rates did not differ from each other significantly, but all were in appreciable excess of the rate of 5.5 among the married. The same distribution occurred among males. Single females, however, had the minimum rate of 1.4, followed by the married with a rate of 2.5. Divorced females had the maximum rate of 5.1, followed by the widowed with a rate of 4.9. Owing to the relatively high probable errors among the divorced groups, the differences cannot be considered statistically significant.

Manic-Depressive Psychoses

Table 11. Standardized Average Annual Rates of First Admissions with Manic-Depressive Psychoses to All Institutions for Mental Disease in New York State, 1929-1931, Classified According to Marital Status*

	Males	Females	Total
Single	15.3± 0.6	19.5± 0.8	17.2± 0.5
Married	7.7± 0.4	15.7± 0.5	11.7± 0.3
Widowed	24.3± 2.4	15.1± 1.1	19.5± 1.1
Divorced	27.0± 7.5	42.8± 8.0	34.8± 5.5

*Population of New York State aged 15 years and over on April 1, 1930, taken as standard.

The married population had a minimum standardized rate of 11.7, the divorced a maximum of 34.8, the latter being in excess in the ratio of 3.0 to 1. The single and widowed had rates of 17.2 and 19.5, respectively, the difference being without statistical significance. Among males, the married had a minimum rate of 7.7, the divorced a maximum of 27.0. The latter rate was in excess in the ratio of 3.5 to 1. The widowed had a relatively high rate of 24.3, which did not differ significantly from that of the divorced. Single males had a rate twice that of the married. Females had higher rates than males, with the exception of the widowed, among whom the male rate was in significant excess. There is no obvious explanation of this result. Among females, the widowed and married had minimum rates of 15.1 and 15.7, respectively. The divorced had the maximum rate of 42.8. The single also had higher rates than the married or widowed.

Dementia Præcox

Table 12. Standardized Average Annual Rates of First Admissions with Dementia Præcox to All Institutions for Mental Disease in New York State, 1929-1931, Classified According to Marital Status*

	Males	Females	Total
Single	64.9± 1.3	46.9± 1.2	55.4± 0.9
Married	11.9± 0.4	19.3± 0.6	15.4± 0.4
Widowed	43.1± 3.2	26.2± 1.5	34.4± 1.5
Divorced	49.0±10.0	54.6± 9.0	51.3± 6.7

*Population of New York State aged 15 years and over on April 1, 1930, taken as standard.

The married had the minimum standardized rate of 15.4, the single the maximum rate of 55.4, the latter being in excess in the ratio of 3.6 to 1. The divorced had a surprisingly high rate of 51.3, which did not differ significantly from that of the single. The widowed population had an intermediate rate. Among males, the married had a minimum rate of 11.9. Single males had the maximum rate of 64.9, which exceeded that of the married in the ratio of 5.5 to 1. The divorced and widowed had rates of 49.0 and 43.1, respectively. Among females, the married group had a minimum rate of 19.3. The divorced had the maximum rate of 54.6, though this did not differ significantly from that of the single.

Summary

The evidence seems clear that the married population had, in general, much lower rates of mental disease than any of the other marital groups. To this there were but two exceptions. In connection with general paresis, single females had a standardized rate of 1.9, significantly less than that of any other marital group. The married population followed with a rate of 4.1. The explanation of this result seems clear. General paresis is a disease of syphilitic origin, and it is well known that the chief source of infection among women is the diseased spouse. Despite the changes in sex mores within the past two decades, it may still be maintained with confidence that single females have less opportunity for infection than married individuals, and consequently have a lower rate of general paresis. Single females also had the lowest standardized rate of first admissions with alcoholic psychoses, namely, 1.4. The married group followed with a rate of 2.5. It seems apparent that there is a greater social restraint upon unmarried females with respect to alcoholic consumption, and this, of course, explains the low incidence of the disorder among them.

As noted in the preceding pages, the fact that the unmarried had generally higher rates of mental disease than the married was noted almost a century ago by Dr. John Thurnam, a medical director of the famous York Retreat in England, and the author of one of the earliest statistical treatises on mental disease. Dr. Thurnam, in seeking an explanation of the difference, refused to ascribe it

to the direct effects of celibacy or matrimony. He was probably the first to suggest that celibacy and mental disease are both joint effects of a third variable, namely the mental characteristics that lead to a celibate existence. He wrote in 1845: "I am indebted to my friend, Samuel Tuke, for the important remark, that our conclusions as to the influence of celibacy (as, amongst other things, predisposing to insanity), as drawn from a comparison of the number of married and unmarried persons admitted into hospitals for the insane, must be allowed to be modified by the consideration that many of the cases occur in a class of persons, as regards mental vigour, less likely to be married than the average of the community at large. In such cases, of course, we must admit that the celibacy is to be regarded as an effect, rather than a cause."[5]

The same type of reasoning was employed by Herbert Spencer in a discussion of longevity and marriage. His arguments were as follows, and in reading we may substitute mental health for longevity. "In three ways does that superiority of organization which conduces to long life, also conduce to marriage. It is normally accompanied by a predominance of the instincts and emotions prompting marriage; there goes along with it that power which can secure the means of making marriage practicable; and it increases the probability of success in courtship. The figures given afford no proof that marriage and longevity are cause and consequence, but they simply verify the inference which might be drawn *à priori* that marriage and longevity are concomitant results of the same cause."[6]

Later writers have employed a similar type of reasoning[7] and one may feel much confidence in its probable truth, even though it is based upon general observations rather than upon exact statistics of the mental characteristics of celibates and benedicts. It does not seem possible, however, to rule out entirely the directly beneficial effects of matrimony, especially in the case of the males. Thus we find that single males had rates more than twice those of married males, with respect to general paresis and alcoholic psychoses, and there seems little doubt that the differences must be due in large part to the stabilizing influences of family life. The contrary results among females have been explained on purely social

grounds. It is a matter of significance that widows and widowers had higher rates of mental diseases than the married. Since, broadly speaking, both groups probably had similar mental characteristics to begin with, the differences in rates of mental disease must be due to the sorrows and tribulations consequent upon the death of a closely related individual, and the subsequent difficulties of economic readjustment on the part of widows. That widowhood entails a severe shock is seen from the fact that in some of the important groups of psychoses, widows had higher rates than the unmarried population. In fact, they had the highest standardized rate of first admissions with alcoholic psychoses. The outstanding result, however, is the fact of high rates of mental disease among the divorced population, rates far in excess of those of any other group. This may be attributed to two sets of causes. The first may be ascribed, as in the case of the unmarried, to selection on the basis of mental characteristics. It is probable that divorced people, in general, are less stable in their make-up than the successfully married. There are in addition, however, certain disruptive forces, associated with a disorganized or disorderly type of life. These are made manifest by the excessively high rates of general paresis and alcoholic psychoses among the divorced groups.

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PSYCHOLOGY OF THE MANIC PHASE OF THE MANIC-DEPRESSIVE PSYCHOSES*

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CONTENTS

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I. Introduction

This communication constitutes a study of the psychological mechanisms which are found to be present in the manic phase of the manic-depressive psychoses. The study itself is primarily a clinical one, and will be directed towards an investigation of clinical case material. It is felt that a study centered on the facts which the patient presents in his psychosis and in his life situations is scientifically sound. Such a study should avoid propounding new theories which have no basis in clinical facts. The principle herein followed will be one of conservatism; the facts presented in the symptomatology will receive first consideration and serve as the nucleus for the consideration of the psychological mechanisms.

A survey of the literature will first be presented. The historical background enables one to properly appreciate the steps through which psychiatric thought has passed leading up to the present-day conceptions. Furthermore the literature contains what is known or has been a matter of conjecture, and furnishes the starting point for further investigation. There have been excellent and comprehensive surveys in recent years, notably that of Lange[31] which brought the literature up to 1926 (published 1928) and that of Ewald[13] appearing in 1930, both surveys being quite broad in scope. There appeared in 1931 the comprehensive survey and bibliography of Hinsie and Katz[22] on the treatment of manic-depressive psychoses.

Kraepelin[30] initiated the move that led to the consideration of the manic-depressive patient in terms of the life history as well as in terms of the clinical syndrome which was present. With the appearance of the various psychological concepts in the latter decades of the nineteenth and early part of the twentieth centuries, the literature began to contain an increasing number of contributions dealing with an understanding of the patient's mental illness in terms of his life history. The contributions of the psychoanalytic school have been particularly numerous and helpful.

The term "manic-depressive" was first used by Kraepelin in the sixth edition of his "Lehrbuch der Psychiatrie" (1899). This term included the entire group of the so-called periodic and circular psychoses and most of the simple manias. He said, "In the course of years I have been more and more convinced that all these pictures are but forms of a single disease process . . . Certain fundamental features recur in these morbid states notwithstanding manifold external differences."

Since Kraepelin's description of manic-depressive insanity, this clinical entity has continued to be accepted with relatively little modification. Bleuler[6] included in his schizophrenia many cases that others would have considered as borderline manic-depressive cases or as belonging in other diagnostic groups. Bleuler's manic-depressive insanity was essentially an affective psychosis in which the "basic symptoms" were: 1. Exalted or depressive moods. 2. Flight of ideas or retardation of the mental stream. 3. Abnormal facilitation or retardation of the centrifugal functions of resolution, of acting, inclusive of the psychic elements of motility.

The scope of this paper embraces one particular aspect, the psychology. It will not be within its province to refer to the contributions in other fields of investigation such as in the field of heredity, constitution, or physiology. The term manic-depressive is quite justifiably to be considered as a joint term covering one broad clinical entity, particularly in view of the present imperfect status of knowledge concerning psychosomatic relationships. The double term manic-depressive, however, has both advantages and disadvantages when one limits one's consideration to the psychological mechanisms which are operating. The literature which deals with the psychology tends to designate the diagnostic group which is under discussion as the "manic-depressive psychoses." A large number of aspects belong to this more inclusive term; and the depressions on the one hand and the manias on the other cannot be discussed without the use of this designation. For example, the pre-psychotic personality traits, the regressive features, the strength of the ambivalence, the love and hate tendencies, etc., are

all attributes of this whole affective psychotic disorder. In the subsequent discussion of the literature and of clinical material the term manic-depressive will of necessity be often used. But the usual contribution in the literature tends to use manic-depressive in the title and then to continue into a discussion of the psychological mechanisms which are functioning in the depressions or in the depressive phases, and to ignore or to pass over rather cursorily the same considerations in the manic reaction. The reason for such a state of affairs is that the manic reaction is less clearly understood. Psychological medicine has reached a deeper and more fundamental understanding of the mental mechanisms in the depressive than in the manic reactions. When the material which the literature has to offer concerning mania is surveyed, there is found to be present much that is clinically sound, and that can be considered as proved on the basis of actual clinical material.

The general plan herein followed will be first, as already stated, a survey of the literature, but a survey that will be limited to that material which concerns the manic reaction alone, or in its relation to the depressive phase if such be present. The second part will consist of a presentation of two illustrative cases with a study of the ideational content. Both these cases are typical manic-depressive patients who were studied for at least several months, during part of which period there occurred a manic phase, in the generally accepted clinical sense. In these case presentations the effort will be towards simplicity and brevity. The third part will consist of critical observations of those aspects of the ideational content which seem worthy of emphasis.

II. Survey of the Literature

The Development of the Concept of the Manic-Depressive Reaction Type

We are indebted to Jelliffe[23] for his historical presentation of the gradual evolution of the manic-depressive synthesis from ancient times up until the present. "Joy and sorrow, elation and depression as 'mood changes' have been recorded ever since records

have been made. They belong to the fundamental formulation of the law of opposites recorded by Heraklitus, and made up the earliest materials for poets. That exaggerations of these came to receive the terms 'mania' and 'melancholia' is also apparent . . . "

"The circular phenomena have always stood out as something unique and striking and down through the corridors of the historical perspective, standardization of this psychobiological reaction type has been evident and is still capable of reconstruction, not alone from the technical works of medicine—always a dubious source for reality search, influenced as they have been by the devious winds of doctrine—but by the fascinating literary records which sufferers from 'this strange malady' have left behind them from Bellerophontes, Nebuchadnezzar, Job, Saul, Horace, King George III, to the 'Mind That Found Itself'."

"Mood swings from one type to another are mentioned by Hipprocrates, by Plato, by Asclepiades, by Aretaeus, Celsus, Galen, Alexander of Tralles, and others but with varying degrees of specificity as to what took place. Certainly the circular types of the manic-depressive cycle were there, but it is highly probable that only in Asclepiades, Aretaeus and Alexander (through Soranus and probably from Aretaeus) are they really unequivocally described. In Aretaeus of Cappadocia[4] (200-300 A. D.) especially does one find the manic-depressive cycle quite specifically delineated. That Aretaeus had in mind any idea of this cycle as a specific disease is quite preposterous to maintain." He saw it and gave the best early description. The following represents Jelliffe's original translation of the essay by Aretaeus entitled "De Causis et Signis Diuture Morb."

"Mania (or insanity) is a continuous disorder of the mind (diuturna ex toto mentis alienatio) without fever. If fever accompanies the disturbance it does not in reality belong to this disease but is the outgrowth of some accidental cause.

"Neither is delirium (Wuth) arising from the taking of specific substances, as wine, hyoscyamus and the like, deserving the desig-

nation of mania, for such disturbances occur quickly and disappear just as quickly.

"Neither should that insanity peculiar to old age be classed here, for this disturbance is due to feebleness, that of mania is due to excitement. Insanity of old age has no intervals of quiescence, and is incurable, whereas mania has intermittent periods and is curable.

"Those who are naturally passionate, lightminded or frivolous, also those of the opposite character are among those inclined to mania. Time of puberty and youth is most favorable for the appearance of this disease.

"The form and ways which mania manifests are manifold. Some are cheerful and like to play, etc., others passionate and of destructive type, who seek to kill others as well as themselves. The seat of the disease is in the head and precordial region. Both regions may be affected at once, or, it may first be one, then the other interchangeably.

"As the disease begins to develop one notices passion, cheerfulness or depression, without cause, there is sleeplessness, headache, ringing in the ears, paralyses, gluttony or loss of appetite, the eyes are sunken and the patient sees various pictures pass before the eyes and the like. At the height of the disease there is a loss of semen, and a period of lewdness and shamelessness exists with the highest type of delirium. If there is a remission of the disease, the patients become quiet and depressed because they are now conscious of their affliction."

Nothing was added to the writings of Aretaeus concerning mania and melancholia until the Elizabethan period in 1602 by Felix Platter. Platter divided mental disorders into four class of which the third was *mentis alienato.* Melancholia for Platter was a form of mental alienation in which the imagination and judgment were perverted in such a way that patients became sad and fearful. His conception of mania included some of the more ancient distinctions, namely that when imagination, judgment and reason were involved this was mania. He put more emphasis however on the excitement in mania. Platter was an excellent clinician, examining his patients carefully and recording his findings well, but he did not appreciate

the aspect of life history and did not seem to appreciate the fact that there occur transitions from one phase to another.

The name *folie circulaire* was employed for the first time by J. P. Falret[14] (1851). He wrote, "This transformation of mania and melancholia, and the reverse, has been characterized as an accidental fact; but it has not been sufficiently noted, or at least it has not been expressly stated that there exists a certain category of the alienated in which this succession of mania and melancholia manifests itself with continuity and in a manner almost regularly." (Jelliffe's quotation of Falret.)

Baillarger[5] (1854) took much trouble to explain that in *folie circulaire* there are not two different attacks—one of melancholia, another of mania—but that both are merely two different stages of one and the same attack. Baillarger gives to this affection the name of *folie à double formé.* (Griesinger's quotation of Baillarger.)

The observations of Griesinger[20] in the second edition (1857) of his textbook "Mental Pathology and Therapeutics" were remarkably sound and did much to clarify the clinical picture of melancholia and particularly of mania. He distinguished mania from monomania. His account of the symptomatology of his manic group would well serve to describe the group just as it is considered today. As a matter of fact many data pointed out by him have with only minor variations or restatements come down to us. His statements are so closely in line with modern psychiatric observations that certain ones will have to be incorporated in the survey of the literature which follows this historical sketch.

Kahlbaum[27] (1863) and Krafft-Ebbing (1874) contributed to the clarification of the mental disorders melancholia and mania, and Mendel's Monograph on Mania[36] appeared (1881). Close upon this came Kraepelin's entrance[30] into the picture. In the first edition of his textbook he followed the older traditions. The second (1887) and third (1889) editions included considerations of certain aspects of the melancholias, and in the fourth and fifth (1896) appeared the gradual unfolding of the final synthesis of the manic-depressive psychoses described in the eighth edition (1913).

The Manic Reaction from the Standpoint of Etiology, Symptomatology, and Psychological Mechanisms

The clinical symptomatology of mania was well described by Griesinger[20] in 1857. He felt that in the majority of cases the melancholia preceded the mania; that in many cases the anxiety, mental suffering and restlessness increased from day to day passing over into mania. "In such cases it is undoubtedly the mental suffering which induces this convulsive disorder." Further, when mania supervened the motor exaltation was set free. Often during the whole course "the melancholia remains behind it as a shady background . . . may even become dominant." One reads nothing here which is at variance with present conceptions.

He described three general groups of symptoms which are as follows:

1. *Anomalies of the disposition, of the desires, and of the will.* There was a desire for ceaseless action and movement, a need for putting thought processes into action. The acts were not reasonable or rational. There was a loss of a sense of decency, modesty and propriety. There was an indifference to one's own family. The sexuality was morbid. There was a desire of possession, the patients collected, accumulated and stole. They spoke loudly and were abusive. Some were angry, defiant, savage in disposition, and others were cheerful, gay, merry, frivolous and on good terms with mankind. "These different dispositions, excitement and prostration, overflowing contentment and utter want of it, alternate frequently." Some patients showed also logomania, poiematamania, dipsomania, edodomania, and homicidal mania. "The nymphomaniacal states do not always manifest themselves by an open expression of the sexual excitation; more frequently they assume a milder form, such as flirting, love of dress, freedom of conversation —much talk about marriage, little equivocations, etc."

2. *Anomalies of the intellect.* The most important change this underwent was "irritability and quantitative exaltation analogous to that of the disposition and the will in a more rapid flow of ideas." There was in more moderate degrees "an exaggeration of the normal faculty for thought," but more often "an incoherence

of ideas—which is the inevitable consequence of the precipitation with which all the psychic phenomena are executed, of the impossibility of the complete development of any complete perception, of the rapid emotional changes, and of the fantastic forms in which their imagination clothes the impressions derived from the organs of sense."

Concerning the matter of temporary delirious conceptions he said: "When a manic often manifests traces of former mental impressions, we may be led to believe that he is incessantly occupied with certain mental causes which have led to his insanity."

He said that in no maniacal state was the conscious thought, the intelligence, free from any disorder; that even in the mildest cases the intelligence participated in the general exaltation, if only consisting of increased liveliness and rapidity of thought, though usually incoherence was present. In stating that "cases can be brought to their senses temporarily" he went on to quote Jessen who had said "the patient is not delirious when he speaks sensibly, and he does not speak sensibly in those moments in which he is delirious."

3. *Anomalies of sensorial function and of movement.* He stated that hallucinations of sight, hearing, smell, and cutaneous sensation were generally of little importance, that illusions of the senses, false interpretations of sensorial perceptions, were much more frequent. False judgments "depend upon non-consideration of certain parts of the sensorial perceptions, and paying great attention to others and upon superficial similarities."

He referred to overactivity of organs of movement , as shown in motor activity, speech, actions, expression, and relative absence of fatigue; also as shown in troubled sleep, increase of appetite, absence of satiety, and a variable increase of the sexual instincts.

The above constitutes the more important statements and ideas of Griesinger concerning cases with the more pronounced manic symptoms. He described also rather accurately and clearly that group with less markedly manic symptomatology which we would at present place in the hypomanic or mildly manic group. His statements will be quoted in view of their clearness and in view of subsequent remarks on regression. "The frequent states of incompletely developed mania are of great practical importance; in

the majority of cases they represent the first stage of exaltation which precedes the outbreak of mania or of monomania, or a period of remission between two maniacal attacks, or even a stage of termination of mania. Occasionally, however, this state continues for a long time in the same manner, and it may then very properly be considered as a special form of insanity with the character of exaltation. We have already in part made mention of this state as a relatively mild mode of expression of certain desires and instincts, while the patient still shows no striking disorder of the intelligence. Frequently, however, there is also observed a general increase of volition not concentrated upon a definite series of objects; and this is manifested as an uncommon and inconstant activity and restlessness, as an ardent desire always to begin something new, as a necessity to alter and remodel the external world according to eccentric projects. Such patients have always something to do—speculations to enter into, to buy or to sell, to present, to build, etc.; all they see or which happens to them they would have and possess, and very often they thereby spend large sums in a very short time. Ordinarily, they are very vain, show a desire to be considered great and to excite admiration; their demeanor is confident and arrogant; the humor generally changes rapidly from joy and frolic to depression, and again to violent outbreaks of anger, the latter especially when their actions are opposed and their pride hurt. Some show a tendency to cunning and intrigue—others a desire to steal, to drunkenness, erotic tendencies, expansive religious ideas. The patients generally talk a great deal, loud and rapidly, but without special delirium; their discourse shows that they have an exaggerated idea of self, but without the delusion of being some other illustrious person; they have merely a tendency to estimate to the utmost their faculties and powers—their wealth, their physical strength, health, or figure. The high estimate which the patient has of himself frequently extends to all that belongs to him, and the mere fact of anything being in his possession is perfectly sufficient to endow it with extraordinary qualities."

The detailed citations from the chapter of Griesinger on manics as they appeared in 1862 hardly need justification. Their clinical accuracy was remarkable. The need for such citations in this com-

munication arose from the fact that subsequent writers have pointed out again and again the facts that Griesinger stated so clearly, particularly in those articles of a general clinical nature. It is not claimed that the above named psychiatrist put forth these as original ideas. Indeed, he referred freely to Jacobi, Jessen, Neumann, Brierre, Esquirol and Pinel. But what he did was to give us a graphic and accurate description of the symptomatology of the manic reaction at that early date, and at the same time to raise certain questions concerning the psychology concerned in this symptomatic picture.

He referred to the frequency of delirious conceptions and false ideas, which were said to be sometimes due to a confused state, but he ascribed more important significance to the "frame of mind" which called forth "ideas of greatness." "The exaggerated idea of freedom and power must, however, have a foundation; there must be something in the ego which corresponds to it; the ego must for the moment become another; and this change can only be expressed by an image, which any momentary thought may create . . . But none of these ideas remained fixed . . . they are dispelled with a new excitation . . . as it passes off no explanation is necessary." . . . "the patient may even laugh at them when present . . . Those cases show a certain relation to children playing a comedy; they enter entirely into the spirit of the play."

"It is worthy of special consideration that in many cases of mania, the intellect—exclusive of the disorders we have just mentioned—seems to be very slightly involved, and that no actual weakness or diminution of it is apparent. Frequently, in spite of great incoherence of ideas, the remembrance of the past is not only perfectly true, but in many cases all that happened during the period of the disease is even well remembered. Not infrequently the patient may, by an appeal to his recollection, be for the moment withdrawn from the whirl of ideas and enabled to answer questions concerning his former life correctly, and even to narrate bygone incidents. Frequently he understands so well all that passes around him and has so much control over himself that a friendly word, a threat, or a joke, or even an appearance of confidence in him, may cause him to become calm for the moment. The perversions of

the judgment, when they do not actually consist of the forementioned attempts at explanation of the disposition, depend merely upon suppression, as if from want of time sufficiently to connect the transient, fleeting, incoherent ideas; sometimes, also, from the predominance of certain series of perceptions which appear to the patient as definite facts. Thus mania, viewed in the double light of a morbid anomaly of the perception and of the will, presents the same general character of an affection of the mind more superficial than profound; and this is demonstrated above all, by the possibility of the sudden appearance of a lucid interval, and even of rapid and complete recovery after the disease has lasted for years —of recovery in which the patient, although his mind is much fatigued, may still be in the complete possession of the former range of his intelligence, and in every way the same mentally as he was before. Frequently, also, he can give an exact account of his state during the disease; and we frequently hear such individuals give vent to expressions like the following statement made by a patient of Jacobi's: 'It is actually terrible when the thoughts so run into one another in one's head.' "

Jones[26] (1909) presented the first case of hypomania in which psychoanalysis had been employed. He stated that the case which Gross reported in 1907 was certainly a case of dementia præcox. Jones' patient was a female, 41 years of age. She had been married at 19 years of age; had one son, then a miscarriage with sepsis. A double ovariotomy was performed when she was 23, a curettement when she was 26. Following this she had a depression lasting six months. She was hospitalized because of an agitated depression at 39 and at 41 she was readmitted in a manic state. She received routine treatment; then psychoanalysis was commenced but not completed. Her logorrhoea was studied. "Complex indicators" were determined. The first group of her ideas were concerning the impurity of her past life, particularly as regards her sex life. The second group of ideas were in relation to her husband and made clear her unconscious striving against the idea of marriage. The third group of ideas were concerned with fellatio, exhibiting the idea that this was the true way to obtain sexual gratification. No generalizations were offered.

Campbell[8] (1914) in a study of the mechanism of some cases of manic-depressive excitement concluded that "the difficulty of adjustment is much less deeply seated than in dementia præcox." His particular cases were aware that they were ceasing to struggle and giving way to tendencies. He emphasized the value of noting the patient's productions as a guide to the study of his conflicts.

Abraham's contribution[1] (1911) marked the first approach to the manic-depressive group by a psychoanalyst. He was conservative in his statements, and they dealt with general clinical considerations from a dynamic point of view. He considered first the depressive and then the manic phase. Essentially he spoke of depression (melancholia) as the reaction to loss of love in persons with strong love and hate tendencies. He referred to his findings in six patients some of whom developed manic attacks. "In every one of these cases it could be discovered that the disease proceeded from an attitude of hate which was paralyzing the patient's capacity to love." The life history of these patients he found to be similar to that of his patients with obsessional neuroses up to a certain point, namely to the development of mental illness. Concerning mania he said, "The onset of mania occurs when repression is no longer able to resist the assaults of the repressed instincts. Positive and negative libido (love and hate, erotic desires and aggressive hostility) surge up into consciousness with equal force." He referred to the regression. "This manic state, in which libidinal impulses of both kinds have access to consciousness, once more establishes a condition which the patient has experienced before—in his early childhood, that is, whereas in the depressive patient everything tends to the negation of life, to death, in the manic patient life begins anew. The manic patient returns to a stage in which his impulses had not succumbed to repression, in which he foresaw nothing of the approaching conflict. (They) often say that they feel themselves 'as though newborn.'" In this retreat to an earlier period the patient indulges in what later writers have termed "wish-fulfillment fantasies." This, Abraham said, constituted one source of pleasure for the manic patient. A second consisted of economy of inhibition. "Whereas the melancholiac exhibits a state of general inhibition, in the manic patient even normal inhibitions

of the instincts are partly or wholly abolished. The saving of expenditure in inhibition thus effected becomes a source of pleasure, and moreover a lasting one. The removal of inhibitions renders accessible once more old sources of pleasure which have been suppressed; and this shows how deeply mania is rooted in the infantile." The third source of pleasure, he stated, was "the technic of the manic production of thoughts. Abolition of logical control and playing with words—two essential features of the manic ideational processes—indicate an extensive 'return to infantile freedom.'"

Abraham in his discussion of the flight of ideas referred to the observation of Liepmann[34] (Über Ideenflucht, 1904) to the effect that in normal thinking the healthy person in his conversation kept in view the *aim* of his mental processes while the manic patient very easily lost sight of that aim. According to Abraham the flight of ideas had a double function: "It makes it possible to glide by means of light allusions over those ideas which are painful to consciousness, for example ideas of inadequacy; that is to say, it favors —like wit—transition to another circle of ideas. And it permits of playful allusion to pleasurable things which are as a rule suppressed."

Abraham characterized the mind of the manic and that of the child as similar in a number of ways, and mentioned one. "In the slighter states of manic exaltation the patient has a kind of careless gaiety which bears an obviously childish character—his rapport (presumably with the psychiatrist) is the same as with a child of about five years of age."

Concerning the mood he said that the frame of mind differed from normal and depressive states, partly in its carefree and unrestrained cheerfulness, partly in its increased irritability and feeling of self-importance. "The severer forms resemble a frenzy of freedom. The sadistic component—instinct is freed from its fetters—reckless and aggressive conduct—trifling occurrences with violent outbursts of anger. Fairly frequently there appear grandiose ideas which are very similar to children's boasts about their knowledge and power."

Reed[39] (1915) described a manic-depressive episode which represented a wish-realization construction. His patient, an unmarried woman of 55, had strong emotional ties to her parents. She developed a depression following her mother's death. After several months her thoughts returned to a nearly-forgotten love fancy of 20 years previous. With this as a nucleus she constructed a systematized wish-realization fantasy involving a change in her personal appearance, wealth, her parents' return to life, good position of her nephew, union in marriage with the object of her earlier fancy, his accession to the presidency, travel, high position, and children.

Dooley[10] (1918) made a distinct contribution to the study of the mania in a detailed report of one case which she had subjected to psychoanalysis. She stated that study of the case confirmed the conclusions of Abraham and MacCurdy "that the conflicts and unsuccessful adaptations leading to this psychosis are of the same character as those leading to the hysterical attacks reported by Freud, and the præcox psychosis of Jung, Jones, Kempf, Meyer and others." She considered the hypothesis was worthy of study that "the type of psychosis developed is the outcome of factors of personality acting upon a biological situation of failure in adaptation common to all the functional psychoses and the psychoneuroses."

Dooley's patient in her symptomatology showed well-marked regressive stages; that is, in the first few months under observation and analysis she developed a manic picture about two weeks prior to the onset of each of her menstrual periods which terminated with the menstrual period. In these episodes her symptoms were of a progressively regressive character. These Dooley rather clearly showed to fall into three general stages, or levels termed: first, "adolescent activities"; second, "infantile fantasies"; and third, "archaic formations."

The activities at the adolescent level consisted of preoccupation with those activities or wished-for activities that had manifested themselves around puberty, such as excessive interest in clothing and in dressing up, adorning herself with a bridal dress, games, debating, pageants and poems, and love of questioning. "She

soon felt the impossibility, however, of getting away from the father fixation sufficiently to choose, and sank, influenced by this among other inadequacies, to the lower level of childhood where her fantasy about her father and her own sex life might have freer play."

In this second stage were a group of fantasies relating to "the father complex" and to infantile curiosity. These fantasies utilized an old myth which she had heard in her childhood; in the elaboration the Kaiser represented her father and she imitated her father in many ways. She expressed curiosity about life processes and the mysteries of adults. She fantasied being a spy in the enemy's country. Her behavior had numerous characteristics of a narcissistic nature and related to her own infantile experiences. She gave away her clothes because she thought that she was going to marry the president. She played at omnipotence, doing things as a joke. This activity was considered to lie between the infantile sort of thought and that confused symbolism, that identifying of self with the external world called archaic. "Finding her desires expressed at the infantile level still incapable of adequate satisfaction she slipped rapidly each month into the third but less clearly defined archaic stratum." These were termed "archaic formations."

This archaic level was considered to consist of an almost undifferentiated chaotic mass of autoerotic wishes and attempts at satisfaction. Among her manifestations were confusion of her own identity with parents, and with the external world, bizarre symbolisms from the plant, animal and inorganic spheres, intrauterine symbolizations, color and blanket symbols and fantasies of impregnation by swallowing various articles.

Concerning regression, Dooley said that it was our most useful conception of mental disease and that every functional psychosis was a regression to a less well-organized and complicated stage of development, and she said that in her patient a two-fold retreat was necessary; first, from a real into a fantastic world; and second, there occurred a compensating activity in fields where there was hope of succeeding. The psychomotor activity, schemes, and inventions were considered to be the patient's defense against her

sense of failure, thus keeping her mind filled with the gratifying sense of achievement. "Defense and compensation thus seem to be the motives for the (manic) psychotic behavior in general; while the nature of her several activities relate to her fundamental complexes. As each arose anew as a stumbling block in the path of self-assertion the point in her life where the painful conflict was initiated was reverted to or lived over."

Dooley[11] (1921) reported a psychoanalytic study of the manic-depressive psychoses in five severe cases, three of whom had had previous attacks. She was impressed by their unresponsiveness to treatment, saying that they tended to bar the truth from the discussions. The most responsive cases among the pronounced psychoses were, she felt, the borderline manic-depressive and dementia præcox psychoses. Such patients had a frank, open, and friendly attitude, combined with a form of quiescence resembling the schizophrenic type of reaction. Four of the five (female) patients reached puberty at an early age. All developed sexual repressions as a result of the mother's failure to meet their needs at a critical time. Their unsatisfied curiosity led to excessive bashfulness, lack of self-confidence, modesty, prudery, and incipient homosexuality. Four were married and their marital relations had been unhappy. Total or partial anaesthesia was the rule.

Dooley described four points of similarity in the manic-depressive psychoses. 1. The wish-fulfilling nature of many of the delusions and irrational ideas. It was felt ("almost dogmatically") "That the patient has the psychosis solely in order to find a vent for these regressive impossible asocial wishes. Inhibitions once removed, wishes take command of the field." 2. The similarity in some points of the manifestations to those of the compulsion neuroses. 3. The regularly graded regression which the psychotic (in general) showed in giving way to hitherto repressed wishes and trends. The manic-depressive type of character was not supposed to regress to depths reached by the præcox patient, but regression did occur to the level of playing with feces. The attitude towards the environment, towards things external, was considered to be that of an extroverted character, the patient's minimizing the subjective element and making use of every object in the range of the

senses. 4. The behavior in the manic attack as a defense reaction. By taking the offensive and throwing herself into all modes of expression it was felt that the patient kept herself safe from the approach of painful thoughts or such feelings as were usually a realization of some failure, degradation, or fundamental inferiority of her own. The manic seldom got away completely from such painful thoughts.

MacCurdy[35] (1924) in his chapters on manic states in his textbook, "Psychology of Emotion," brought up to that date his clinical studies of that disorder. His presentation was a clinical one and while many excellent observations were made, some points which he emphasized do not now seem to deserve the emphasis he gave them. His discussion considered sublimations, precipitating mental causes, elation and other emotions, the distraction of thought and its degrees in manic states, explanation of the mood variations, the prognosis, some excellently presented clinical cases, and concluding generalizations.

The term sublimation he felt that he used in a broader sense than did Freud. "Sublimation seems really to be the union of selfish and social tendencies in some activity which is a substitute for more primitive and selfish ones." The excessive and diverse activity in manic states he construed as coming within the scope of sublimations. The accuracy of this conception will not be discussed here, but rather several of his clinical observations concerning the manic symptomatology are of importance and should be mentioned.

The fact that earlier familial attachments remained of importance seemed proved because in manic states the physical sexual act was rarely mentioned, even when lovers were mentioned, and because in the shifting mental content there was an interchangeability of sexual and non-sexual ambitions.

The regression in the manic state to a more primitive level was felt to explain the change in the activities ("sublimations") from an adaptive to a non-adaptive character—(not practical, less adapted to adult life, such as fantastic business schemes). "In benign psychoses (manic-depressive insanity) the fundamental biological repressions (that is, the deeper ones) continue to operate while, as a part of the general failure of adaptation implied in all

insanity, conventional inhibitions are lifted. Therefore we find in manic states ideas to be classed, broadly, as sublimations, but often crudely unconventional." One would agree, except as regards designating ideas as sublimations.

These ideas, he showed to differ in their general content in the two sexes. Women seemed to indulge themselves in fancies of lovers whom they identified indirectly with the father or portrayed in a direct union with the father with sex consciously eliminated. Men, he said, seemed more given to inflate themselves with fantastic schemes, business or professional, or with the development of philosophical, religious, or pseudo-scientific theories (prophets, leaders of thought, hypnotists, telepathy masters); they hoped to solve moral and physical problems at one stroke.

Every benign functional psychosis was said to result from three factors: 1. A faulty make-up, referring to the personality. 2. The intolerable situation, referring to chronic stress of any sort. 3. The precipitating mental causes. These he separated into four rough groups, and illustrated with case material. These were: first, direct opportunity for adult wish-fulfillment; second, veiled outlet to an infantile wish; third, plain infantile wish-fulfillment which was quickly distorted in adult formulation by means of autistic elaboration; fourth, distortion of a distressing idea into a sublimation.

MacCurdy studied the range of ideas in manic states in many patients, and in patients during recurrent attacks. He found that they fell into a very few (five) limited groups: 1. There was constant talk of sublimations (using the term in the narrower sense of natural activities). These were "psychotic" because the element of personal ambition was so stressed as to exclude other considerations and therefore causing lack of judgment as to the propriety and expediency of these schemes. 2. There were sometimes engrossing religious ideas, which, as a rule, showed a primitive and childlike egocentricity, and were often the vehicle for crude expansiveness. 3. They often luxuriated in fancies of unconventional but adult love affairs. 4. They spoke of a return to childhood with a fantastic re-establishment of the nursery attachment in which the element of sex ("in its commoner meanings") was eliminated. 5.

In the background were scattered references related to the getting rid of adult responsibilities, such as routine duties, marriage ties and business (often shown in conduct, when wife was irritable towards husband, man left his job, etc.).

Concerning the attention and the distractibility of thought MacCurdy summarized his observations as follows: "The rationality of the patient's utterances, intelligibility of his conduct, and disturbance of orientation are all directly proportional to the degree of absorption in thoughts of unconscious origin. The essence of the manic state is the absorption of the patient's interests in autistic thoughts; more adaptive thoughts in milder cases, less so in more florid cases, even to the point of apparent disturbance of intellectual function."

In the more extreme manic states with greater distraction he said that "the tendency of the unconscious fancies to assume more primitive forms" was magnified; the ideas were reduced to their original crudity, were apt to appear as ideas of danger, to appear in an antisocial form, and as a death idea (as in stupor). "What we observe is an alternation of moods, or a reduction of intensity of elation which corresponds to the patient's further divorce from reality."

MacCurdy considered that there were two aspects of regression. First, there was a return to earlier interests or objects of attachment. In dementia præcox there was seen a tendency to return to undisguised infantile sexuality, while in manic-depressive psychosis the parent was seen as the object of sexless attachment, and the sexual partner, if mentioned, was outside the family (a surrogate). Actually, the gradations of regression between puberty and infantilism were considered to be present though the regression was largely to the period of psychological puberty in milder cases. Second, there was a regression, or return to more primitive kinds of thinking with unstable powers of discrimination. "The child lacks the adult type of consciousness; he is a mass of poorly combined relatively independent reaction tendencies."

Kempf[29] (1921) wrote concerning the mechanism of the manic phase of the "manic (erotic) flight." "In the manic (erotic) flight the individual enjoys the unrestrained delights of a divine amour

with the heavenly love-object of infancy (daughter—F and M—son). When the wish for this love-object is renounced as shameful and incestuous, the individual deprives himself of the chief source of stimulating energy and inspiration for sublimation. The affective attachment to the mother, *when* sublimated, drives him on to become virile and good in order to create in maturity situations and images that will gratify the childhood love. When this wish is renounced or betrayed, life becomes an onerous burden, the affections tend to regress to the state of dependence upon the mother which existed before the weaning or even before the parturition."

Kempf considered the manic psychoses as compensation neuroses, of which he described two types, the distinctive difference in the mechanisms being the affective complication of *fear,* which was absent in one type and an important factor in the other.

That type which was free of fear ran the shortest course, was less severe in its physiological stresses, was less complicated, and since it did not distort the affective functions offered a better prognosis. The manic patient who was not afraid, Kempf said, delighted in being touched, loved attention, had a good appetite, and "will recover from the affective dissociation so soon as the uncontrollable craving is satisfied and temptations to live a constructive social life are sufficient to induce sublimating."

The complication of fear was shown to be present in manic states by the patient's distrust of treatment, eccentric or diminished appetite, extravagant claims and demonstrations of power (for defense); whereas in depressed anxious patients almost every unknown thing in the environment caused fear of inquiry or seduction. This type he considered as a hostile compensation for the fears caused by tabooed erotic cravings, these cases having affected boldness and bluff so vigorously as to have intimidated others and so to have masked their underlying fear.

The appearance of the manic state Kempf felt to result when some failure which had discouraged the struggle for social esteem occurred and weakened the restraining forces of the personality. The individual then quit the struggle of refining the erotic cravings and, with unrestrained expressions of delight, abandoned him-

self to the "affective flood and the orgies of fancies and wild, free self-indulgence."

The first contribution of Freud[18] towards the understanding of the mania was "Mourning and Melancholia," which appeared in 1916. That portion dealing with mania was more speculative and less helpful than that relating to depressions (melancholia).

Freud considered that the problem of mania might be approached from two points of view, first, from a psychoanalytic, and second, from general observation in mental economics. The first he disposed of by stating that several analytic investigators had expressed themselves as feeling that the content of mania was no different from that of melancholia, that both were wrestling with the same "complex," that in melancholia the ego had succumbed to it, whereas in mania the ego had mastered the complex or thrust it aside.

"The other point of view is founded on the observation that all such states as joy, triumph, exultation, which form the normal counterparts of mania, are economically conditioned in the same way. First there was always a long-sustained condition of great mental expenditure, or one established by long force of habit, upon which at last some influence supervenes making it superfluous, so that a volume of energy becomes available for manifold possible applications and ways of discharge—for instance, when some poor devil, by winning a large sum of money, is suddenly relieved from perpetual anxiety about his daily bread, when any long and arduous struggle is finally crowned with success, when a man finds himself in a position to throw off at one blow some heavy burden, some false position he has long endured, and so on. All such situations are characterized by high spirits, by the signs of discharge of joyful emotion, and by increased readiness to all kinds of action, just like mania, and in complete contrast to the dejection and inhibition of melancholia. One may venture to assert that mania is nothing other than a triumph of this sort, only that here again what the ego has surmounted and is triumphing over remains hidden from it. What has happened is that the economic condition described above has been fulfilled, and this is the reason why the maniac is in such high spirits on the one hand and is so uninhibited in action on the other."

Freud then put together the two suggestions with the following result: "When mania supervenes, the ego must have surmounted the loss of the object (or the mourning over the loss, or perhaps the object itself), whereupon the whole amount of anti-cathexis which the painful suffering of melancholia drew from the ego and 'bound' has become available. Besides this the maniac plainly shows us that he has become free from the object by whom his suffering was caused, for he runs after new object-cathexes like a starving man after bread." These suggestions, while plausible, he said, were too indefinite and gave rise to more new problems and doubts than could be answered. In pursuing the question further he pointed out that of the three conditioning factors in melancholia, namely loss of the object, ambivalence, and regression of the libido into the ego, the first two were found also in the obsessional reproaches arising after the death of loved persons. The ambivalence motivated the conflict and observation showed that no manic state resulted. He felt that the third factor, the regression of the libido into the ego, was the only one that could be responsible for the manic state. "That accumulation of cathexis which is first of all 'bound,' and then, after termination of the work of melancholia becomes free and makes mania possible must be connected with the regression of the libido into narcissism."

Freud's next consideration of the manic reaction occurred in his "Group Psychology and the Analysis of the Ego"[19] (1923). Here he said: "It is conceivable that the separation of the ego ideal from the ego cannot be borne for long, and has to be temporarily undone." In all renunciations and limitations imposed upon the ego a periodic infringement of the prohibition is the rule; this is shown by the institution of festivals, which in origin are nothing more nor less than excesses provided by law which owe their cheerful character to the release they bring. He referred to the Saturnalia of the Romans and to the festivals of primitives which usually ended in debaucheries and transgressions of what were otherwise sacred commandments. "But the ego ideal comprises the sum of all the limitations in which the ego has to acquiesce, and for that reason the abrogation of the ideal would necessarily be a magnificent festival for the ego, which might then once again feel satisfied with itself."

Because of the use of the concept *ego ideal* and Freud's use of that term in his communication, his definition, as given in the same paper is being quoted. "We have called it the 'ego ideal,' and by way of functions we have ascribed to it; self-observation, the moral conscience, the censorship of dreams, and the chief influence in repression. We have said that it is the heir to the original narcissism in which the childish ego found its self-sufficiency; it gradually gathers up from the influences of the environment the demands which that environment makes upon the ego and which the ego cannot always rise to; so that a man, when he cannot be satisfied with his ego itself, may nevertheless be able to find satisfaction in the ego ideal which has been differentiated out of the ego. In delusions of observation, as we have further shown, the disintegration of this faculty has become patent, and has thus revealed its origin in the influence of superior powers, and above all of parents. But we have not forgotten to add that the amount of distance between this ego ideal and the real ego is very variable from one individual to another, and that with many people this differentiation within the ego does not go further than with children."

Freud felt that there was always a feeling of triumph when something in the ego coincided with the ego ideal. "Let us keep to what is clear. On the basis of our analysis of the ego it cannot be doubted that in cases of mania the ego and the ego ideal have fused together, so that the person, in a mood of triumph and self-satisfaction, disturbed by no self-criticism, can enjoy the abolition of his inhibitions, his feelings of consideration for others, and his self-reproaches."

Abraham[2] in 1924 felt that he was able to confirm Freud's conclusions concerning the formation of the super-ego, and went on to consider melancholia and mania from the standpoint of the development of the libido. In brief, he indicated that the incapacity in melancholia sprang from the strong ambivalence; he drew attention to the large part played in the mental productions of such patients by cannibalistic and oral instinctual impulses; he felt from the patient's childhood histories that they had experienced a "primal depression," suffered at the height of the Oedipus development as a reaction to their double disappointment of their love for the mother and father.

Abraham in his section on mania prefaced his remarks as follows: "Freud . . . has investigated much more deeply into the nature of depressive states than into that of the manic ones. . . . I am able to add to the material gained by Freud on this subject only in a very slight degree and in but few respects."

One of the principal respects in which the two conditions, depression and mania, differed was in the relation of the individual to his super-ego. "In melancholia we see the super-ego exercising this function of criticism with an excessive severity. In mania, on the other hand, we see it use no such harsh criticism of the ego. We see that the manic patient has thrown off the yoke of his super-ego, which now no longer takes up a critical attitude towards the ego, but has become merged in it. We are reminded of our earlier observation that the circular type of patient has a very ambivalent attitude towards his ego. And we may add to Freud's statement and say that the withdrawal of his super-ego allows his narcissism to enter upon a positive pleasurable phase."

Abraham said that in mania the individual turned his libido to the outer world with excessive eagerness, that this was based on an increase in oral desires, and an urge to assimilate into himself all objects. He went on to say that the act of expelling, casting aside, or discarding these objects as soon as they had been received was equally pleasurable, and that in mania all objects were regarded as material to be passed through the patient's 'psychosexual metabolism' at a rapid rate. "Anyone who has listened to the association of a manic patient will recognize that his flight of ideas, expressed in a stream of words, represents a swift and agitated process of receiving and expelling fresh impressions."

Abraham considered the criminal fantasies of the manic patient to be directed for the most part against the mother but that in the first instance they were directed against the father. These thoughts, or crimes, he felt were carried out from time to time on a psychological plane in mania and melancholia just as primitive people performed it in a ceremonial way at their totem feasts (Roheim: "Nach dem Tode des Urvaters," 1923).[41]

Schilder[42] attempted in 1921 to explain the psychology of mania. He said that in the manic state unpleasant experiences surged up

from the memory; that the reaction to these was a lively cheerfulness the purpose of which was to overcome painful experiences. These experiences, he said, were not overcome but existed in the mania inciting further liveliness and flight of ideas. He believed that every psychic conflict put defense reactions into motion which strove to overcome the unpleasant experiences and derived pleasure from the victory; that this victory also had a further purpose, namely to render the individual capable of new undertakings, to give him freedom of action. This combination of pleasure and action Schilder designated by the terms 'manic fluidum.' This fluid he considered as a sort of reservoir which existed in normal people; was stored up for meeting pressing problems, and could be set free by the disappearance of the problem (as when a poor man becomes rich, when a person believed dead is found to be alive, etc.).

In 1926 Schilder[43] again emphasized the importance of painful memories. "In all manics I have repeatedly found that the elation, the sense of well being, is disturbed by the pricking of painful experiences of the past. In the manic attack—the painful past is ever present." He received the impression in certain cases that the manic attack enacted all in connection with painful and unpleasant experiences of the entire life; that the manic was continually overcoming this unpleasant past with the stimulus of the painful nature remaining present.

He suggested that perhaps the manic attack depended not on the nature of the conflict but on the overcoming of it; that every unpleasant experience withdrew libido from the ego, depressing the individual, until his defensive powers were finally discovered, at which time these defensive powers broke forth in an exaggerated measure with the accompanying picture of mania.

Schilder pointed out, as others had, the fact that in every thought phenomenon opposing motives had to be overcome (ambivalence) and that with the decision there occurred a release and sense of well-being.

Finally Schilder stressed the importance of the biological factor and of heredity. Earlier pathological experiences or disappointments he considered necessary, and these the biological swing

might search out. "There is in those who become manic a biologic reservoir which demands too much."

Jelliffe and White[25] in their textbook (1929) wrote: "The manic-depressive psychosis may be conceived of as an effort at compromise and defense resulting from an endopsychic conflict. In the depressive phase the affect has broken through and invades consciousness, while in the manic phase the patient by feverish and restless activity, by a constant alertness, fights off every approach that might touch him at a painful spot. And so the manic patient is quite inaccessible and all of his reactions are especially superficial, as witness the word associations and the clang associations. He moves over the surface—in order to prevent penetration at any point." In short, the constant activity was considered as a defense against painful endopsychic conflict.

They considered the constant activity in its varied manifestations as a "flight into reality." "In this constant activity of which such symptoms as . . . are types, the patient is constantly occupied with reality . . . Little that occurs about him escapes him—showing keen powers of observation—as a means of escaping from the conflict." They termed it as an "extraversion psychosis," saying that the manic patient "attempts to escape from his conflict by a flight into reality rather than by a path that leads, by introversion, through the conflict, as is so often the case in præcox." The manic patient "seems to assure himself that he again and again is able to rehabilitate himself."

To Rickman[40] (1928) the condition of the ego seemed to be important. He pointed out that in the melancholic phase the acutest pain was borne by the ego, and that when the manic phase came there was a sudden release of strain and the patient appeared to be joyous. The change he felt might be put in terms of the difference in tension or hostility between the super-ego and ego. "That the condition of the ego seems to be important is shown by a further fact, that mania is much more infantile in character, or rather that the manic's ego activities, as well as his libidinal, are more infantile. . . . "To give an illustration: in the depressed phase a patient had prospect of a rise in the business world but feared that he was emotionally incapable of doing the extra work involved; he saw his

career clearly, the present, past and future, and was aware of intellectual proficiency. Later in the manic phase he decided to cling to his present job, dwelt on its trivial pleasantnesses and behaved childishly about the past in retrospect. As to the future: 'I don't give a damn what happens. I'll stick where I am till hell freezes.' Comprehension of surroundings is, of course, in melancholia impaired in most cases to a greater or lesser degree, and overcast with uncertainty and portents of evil, but it retains its character of comprehending (bringing elements together) though the total range is restricted. In mania this is not so; here details, isolated elements or small combinations seem to function in the mind where larger combinations function in depression."

Radó[38] (1928) went further into the analysis of the ego and its narcissism in order to penetrate more deeply into the nature of melancholia and mania. He began by agreeing with Freud in that the deepest fixation point in the depressive disposition was to be found in the "situation of threatened loss of love," (Freud) more precisely "in the hunger situation of the infant." He postulated a state of "oral-narcissistic bliss" associated with the "satiety and satisfaction" accompanying the nursing of the infant at the breast, this amounting to a pleasurable state designated "alimentary orgasm," this orgasm constituting a precursor in the scheme of growth and development to genital orgasm. This alimentary orgasm in its total setting, he indicated, satisfied the egoistic cravings of the baby for nourishment, warmth, security; fulfilled the longings of his budding object-instincts, and by the blending of all these factors it induced in him a kind of narcissistic transport which was inseparably connected with those satisfied cravings. In other words, this experience contained all the components which subsequent development would differentiate and carry forward to different fates. "It can't be denied: in this the infant's dawning ego acquires a narcissistic gratification which he will later experience as self-satisfaction."

Radó felt then that self-esteem, meaning narcissism, could be traced in development through the oral to the anal and to the genital level but that the original peculiar quality of the experience per-

sisted "as a specially differentiated memory symbol of that early ego-reaction which was conditioned by the alimentary orgasm."

Radó referred to Freud's concept that in mania the ego was once more merged with the super-ego in unity. "We may add that this process is the faithful intra-psychic repetition of the experience of that fusing with the mother that takes place during drinking at her breast. The earliest (oral) technic for the renewal of self-satisfaction is revived on the psychic plane and results—as is psychologically perfectly correct—in the transports (intoxication) of mania. The manic condition succeeds the phase of self-punishment with the same regularity with which formerly, in the biological process, the bliss of satiety succeeded to hunger."

Concerning the transition from melancholia to mania, Radó pointed out that the melancholia represented an effort at solution; that this effort took place, not in relation to the object world, but entirely within the separate institutions in the patient's mind. He said: "The final reconciliation with the object (after this has been replaced by the super-ego) is accomplished not as a real process in the outside world but as a change of the situation (cathexis) in the psychic organization. From this purely psychic act, however, there ensues an important *real* result, the restoration of the subject's self-esteem—indeed, its leap into the exaltation of mania. The difference is clear to us: the melancholic process, set going by a grievous shattering of the subject's *narcissism,* can by means of a purely psychic shifting of cathexis attain to its narcissistic goal (the restoration of self-esteem), even though reality be thereby ignored. Once passed into the state of mania, the ego immediately finds its way back into the object-world. With all its energy released by the sudden change in cathexis it rushes upon reality and there expends its violence. What determines the behavior of the manic patient is the oral derivation of the psychogenic transport; it is a striking fact that in mania the adult with his manifold potentialities of action and reaction produces the uninhibited instinctual manifestations which we observe in the euphoria of the satiated suckling. That the quality of the reactions of a period of life in which the super-ego did not as yet exist should be the pattern upon which is modeled the manic state (the basis of which is a temporary

withdrawal of the super-ego) is exactly what we should expect."

Alexander[3] (1930) included his explanation of the mechanisms in the manic-depressive psychoses in his theory of the neuroses. He felt that in this condition just as in hysteria there was simultaneously a wish-fulfillment and a self-punishment; so in all other neuroses these two antagonistic tendencies somehow came to expression. This, he said, was especially clear in manic-depressive conditions. "The manic period is completely under the sway of the uninhibited living out." "In the depressive period self-punishment, turning of hostile strivings against the self, dominates the picture entirely."

Freud'[8] had spoken of the causal psychological relations of the two periods (manic, depressive); namely that one phase was the psychological reaction to the other. Alexander said that from this it became clear "that the manic-depressive mechanism was only an individual case of a general principle operating on the neurotic psyche." "What happens in the manic-depressive neurosis in separate phases (namely the manifestation of the repressed tendencies in mania and of the punishment in the depression) appear at one and the same time in the compulsion neurosis." "Defusion (of instincts) is minimal in hysteria, greater in compulsion neurosis, and maximal in manic-depressive neurosis where the equilibrium between the two antagonistically directed forces is completely destroyed."

The report of the Association for Research in Nervous and Mental Diseases (1931) contained several contributions which were related to the topic under discussion, notably those of Kasanin[28] and Lewis[33] which will next be considered.

Kasanin[28] studied the affective psychoses in children. His case material consisted of 10 patients, six boys and four girls, with ages from 11 to 15. The first two showed hyperkinesis; that is, extreme restlessness, excitability and irritability since early infancy. The other eight showed mood disturbances with well-defined elation or depression. The mild hypomanic periods were of the same frequency as the depressions, the manifestations were milder than in adults, and severe excitement was absent. The manic symptomatology consisted of mild elation, overactivity, irritability, and push

of speech. (The depressive symptomatology consisted of withdrawal, undertalkativeness, general retardation, and occasional refusal of food.) The clinical picture was not always clear-cut.

Lewis[33] psychoanalyzed four manic-depressive patients who had shown depressive and manic features at various times. He summarized each case history giving consideration in sequence to a general description of the setting, the symptom expressions, information gained through psychotherapeutic interviews, dreams if present, associations and therapeutic results. He then in a summary of the general trends pointed out that there was a striking similarity in most of the fundamental factors, with some variations in individual patterns. The following were the outstanding elements:

1. "There was observed a conscious strong attachment to the parents with more or less unconscious love and hate ambivalencies, which do not mature and differentiate, and make for infantile modes of reaction in society and particularly in married life."

2. "The capacity for love and hate is very highly developed, with the sadistic components often more openly expressed during the elated phases and more deeply repressed in the depressed, pessimistic, accusatory and 'sense of guilt' periods."

3. "There is a notable uncertainty of the sexual rôle—in the polarity of feminine and masculine tendencies as shown by the overflow of sexual energy into several channels."

4. "Plenty of oral elements appear in the waking content and in the dreams; they are usually more scattered and not so characteristically of a deeply sadistic nature as in the cases of involutional melancholia and of agitated depression. The regression is apparently less deep."

5. It was felt that the reaction could not be interpreted entirely in terms of regression in view of such factors as the excess of labile sexual energy and the biochemical foundations of the instinctual urges. The possibility that the accumulation early in life of sexual or creative energy in the organs without the possibility of adequate or satisfactory removal must either create tension or force outlets into other channels was considered.

6. The regression seemed largely to the level of secondary narcissism. In cross section there were aspects of a not deep nature characterized by compensatory balancing, and hypercompensatory features. "The various well-known mood reactions, psychic tempos, psychomobility expressions and social standardizations characteristic of the elated and depressed phases are sufficient to explain this point."

Lewis enlarged on the topic of regression. Ambition, aggression, and striving to get ahead in the world were said to be related to the creative or reproductive instinct with the principal structural focus in the genital organs. This goal the cyclothymic repeatedly failed to reach and with releasing factors of regression there occurred "a regression to an early childhood type of behavior similar to that in vogue before the narcissism became genitalized." "The symptoms depend upon the nature of the development of the personality through the early childhood narcissistic stage since there is a periodic regression to this behavior in the form of an elation with overemphasis of self-esteem or of the ego and with a reduction of all values to the same level. In both sexes the ego becomes very expansive with the body highly narcissized and the bid for attention increased through decorations and exhibitionistic postures and attitudes which are often seductive in import."

The various symptoms such as the flight of ideas, punning on words, the writing of numerous letters, the lavish spending of money, the making of countless plans and schemes for universal and personal improvements he cited as indications of the intense struggle toward the attainment of the ambitious goal, and as attempts to completely overthrow the super-ego.

Deutsch[9] (1932) made a psychological study based partly on clinical, partly on psychoanalytic observations, of various forms of manic-depressive psychoses with special reference to intermediate states, such as those of irritable depression and the "so-called irritable mania." She felt that the clinical picture took its coloring from the type of defense mechanisms resorted to by the ego against the destructive forces, and that the process of defense was determind by the extent to which ego-development had held its ground against the impetus towards instinctual regression.

She stated that light was thrown on manic states, especially by those cases where the preceding depressive state was either very slight or even displayed the character of an aggressive struggle with the outside world. In such cases the defensive forces of active projection were said to be succeeded by a mechanism which was specific for mania, namely *the mechanism of denial,* by which the ego attempted to cancel the narcissistic injuries which it had sustained, and behaved as if these had never existed, or had subsequently been made good. Such denial rendered aggression against the outside world unnecessary and protected the patient from his reactions to loss and from the "primitive severity of the super-ego." If a melancholic attack, she went on to state, had gone before, with its activities of punishment and expiation, it would assist the mechanism of denial to function, would make the denial more pronounced, and would impart to mania the familiar character of triumph.

Lewin[32] gave a description of the personality structure as seen in a case showing transient hypomania. (Female under analysis for hysterical symptoms.) The points as Lewin emphasized them were as follows: The ego fused with the super-ego by an oral mechanism. The resultant "hypomanic" ego was a purified pleasure ego, ingesting the sources of pleasure, ejecting the sources of pain by denying. This new ego contained the parental identifications which had been previously present in the super-ego. To quote: "There has, indeed, been a reversal of the process which led to super-ego formation." In the patient in question "the super-ego disappeared, and the relationship with the first libidinal object for the id, the parents, represented in the ego by identification, was resexualized." These identifications were sexualized, and the sadism previously emanating from the super-ego, but during the hypomanic episode present in the ego, was turned against the environment, partly in denial of parts of reality or in denial of the intrapsychic representatives of reality which might have been causing pain. The content of the hypomanic attack Lewin felt from the clinical material presented was an identification with both parents in coitus.

Lewin[22] tended to feel that if the hypomanic state were structurally the same as an identification with both parties in coitus, it would be possible to derive the formal, general characteristic elements of the neurosis (or psychosis) from the elements present in coitus. He postulated these analogous elements in coitus observation and in the hypomanic attack.

Coitus observation	*Hypomanic attack*
Two active participants	Bisexual productions
Motion of adults. Immobility of children	Motor overactivity
Sounds from adults	Sexual excitement
Adult's orgasm. Child's orgastic equivalent	Expulsion (Abraham)
A "celebration"	A celebration (Freud)
Stimulation of fantasy in child	Flight of ideas
"Violence" of adults	Aggressive symptoms

In support of his reasoning concerning coitus observation and its relation to hypomanic symptoms, Lewin referred to an observation of Abraham,[2] to another case of his own, and to two cases reported by Nunberg[37] and Brill.[7]

Abraham[2] observed that there was an increase in sexual desire and in sublimated activity following normal grief, an "acting out," so to speak, of the primal scene in a normal way, and his conclusion was that this state was the normal analogue of mania.

Lewin saw a young man for several hours during a short manic attack (who was not analyzed) and obtained the following impressions: His manic state had begun while he was under considerable pressure to start his overt sex life. "In his illness he spoke of the sexual significance of eating and the bisexual nature of the individual. He was enthusiastically listing his talents and capacities according to their origin from father or from mother."

Nunberg[37] described a young man with compulsion neurosis who had "Saturday depressions" preceded by Friday night hypomanic moods. They were considered as reactions to the fact that his parents engaged in sexual relations regularly every Friday evening. Nunberg stated: "Identifying with his mother and the Sabbath, he formed oral fantasies in which he not only desired the father but identified with him also."

Brill[7] reported a transient hypomania in a female which interrupted a compulsion neurosis. She had been under treatment about

a year and became absorbed in the details of the Snyder-Gray case, in which a man named Gray and a woman named Snyder, his alleged mistress, had murdered the woman's husband. The patient developed transient hypomanic symptoms, this representing a double and symbolic identification with a man and a woman dying together.

Lewin tended to avoid dogmatic assertions and put forth his suggestions in a tentative manner, subject to subsequent support by others in comparable clinical material. One feels that the aspect of "hypomanic" ego is merely another of the manifold manifestations of the regression, and that expressing this in terms of the ego and super-ego structure and development is quite helpful. The details of the case leading to the conclusion that the patient identified herself with both parents cannot be given in detail here.

Eddison[12] (1934) considered that the manic, in his symptoms, made a desperate effort at transference, but that the part was overacted (as shown in hostility, abusiveness, euphoria and expansiveness), and that the underlying attempt at negative transference was really revealed. This underlying hatred was said to be manifested towards both sexes alike, with surrogates ever changing, and with the patient making frequent mistakes in identity. The idea was expressed that due to the imperfect capacity for transference the patient made the general public his mother and that in his attitude to the environment he was expressing his hostility against his mother.

Eddison presented briefly two cases. The first was abusive and hostile to the physician and others. This negative transference was his main channel of contact with reality and his childish dependence on the nursing staff showed the ambivalence and infantile nature of his incomplete transference. This environment the writer referred to as representing the mother externalized. The second case "externalized his mother" in accusing those caring for him of lack of attentiveness.

These observations constitute another way of saying what Radó[38] emphasized; namely that the narcissistic need of love from parents or their representatives is strong. The "mother" and the "en-

vironment'' as Eddison referred to them seem fundamentally to mean the kind parent.

Fenichel[15] (1934) made a notable contribution to the subject under consideration in his recent book, ''Outline of Clinical Psychoanalysis.'' The present theory, so far as it goes, of the manic-depressive psychoses, was given concisely, clearly, conservatively and what he had to say represented a resumé of the work of the various recognized psychoanalytical investigators. While the theoretical aspects were well presented, there was a dearth of clinical case material, the lack of which must be expected in such a highly condensed exposition.

Fenichel's initial remarks were helpful in their orientation. ''The studies made have yielded much fundamental information with regard to the earliest evolutionary stages of the ego and libido; but as regards the theory of the disorder itself our knowledge is still incomplete and many problems still await solution.'' He cited three considerations which cautioned us not to overrate the etiological importance of the psychogenic factors: ''(1) The strict periodicity which characterizes the alternation of mood, particularly in the most typical cases; this periodicity appears to be independent of any external event and to indicate the operation of a biological factor. (2) In no other neurosis is there such definite evidence of hereditary transmission (the same state recurring in successive generations), which also indicates a biological basis for the reaction. (3) Even in cases where the course is not markedly periodic, the spontaneity of the mood alterations, which occur without apparent external precipitating cause, is against their being purely psychogenic.'' Despite the importance of these aspects, he urged that psychogenic factors were nevertheless important and that their investigation was decidedly indicated. He said before going further, concerning the manic-depressive group: ''To anticipate, we may record here the formulated result of psychoanalytic study: The ego of the depressed patient is at odds with its super-ego. Indeed, the independent existence of the psychic agency known as the super-ego was first recognized by a study of depression. For the effectiveness of the super-ego's operation becomes evident only when it is at odds with the ego, which, to be sure, is the

case in all normal bad conscience—but which becomes evident to an extreme degree in the depression. In other cases super-ego and ego are inseparably fused" (referring presumably to mania).

Fenichel then discussed the contributions which furnished the basis of our knowledge of the depressions. Turning then to the nature of the manic attack he said that it presented to the psychoanalyst a much more puzzling problem than did depression. The contributions by Abraham, Freud and Radó particularly were considered fundamental. The contributions of value have already been reviewed, and those topics which Fenichel emphasized and summarized in the most clear manner possible will merely be indicated as factual statements without elaboration, critical or otherwise, in the following two paragraphs.

Concerning the ego and super-ego relationship he wrote: "In a manic state the difference between the ego and super-ego must disappear completely." "In mania the ego somehow succeeds in freeing itself from the terrible pressure of the super-ego; it terminates the conflict with the 'shadow' of the lost object by absorbing the super-ego completely into itself; and then as it were celebrates this event." "The manic-depressive is ambivalent to his own ego, and in depressions he demonstrates the hostile element of his ambivalence which is directed against his own ego; mania brings to the surface the other aspect of this ambivalence—the extreme self-love of this same person." "The essential content of the mania is the 'shaking-off' of the super-ego (or of the introjected object) by the ego, and a sort of triumphal celebration of the success of this venture comparable to the totem feast of the primitive races."

Concerning narcissistic need for love and self-regard he wrote: "The importance of 'self-regard' in the manic-depressive group makes a badly needed summary of the whole topic very difficult." After the original infantile feeling of omnipotence is lost there is a persistent desire to recover it, termed "narcissistic need," or self-regard. This self-esteem is greatest when the child feels that he is being loved, lowest when love is withdrawn or absent. The baby's desire for milk constitutes the earliest form of hunger and its satisfaction produces satiety or the "alimentary orgasm." "There

are some people whose self-regard is fixated in some special way and the fixation, like any other, may take its origin in constitutional or accidental factors." Accidental ones are early insults to narcissism, that is, impairment of the child's self-esteem when he feels that the adults about him have ceased to love him. Such incidents in predisposed children may result in a heightened fear of losing love and influence the choice of love objects to the end that even later in life there is a tendency to select their love objects on the basis of receiving that love and kindness which will gratify their infantile needs for the boosting of their own self-esteem, or narcissism. There is a heightened fear of losing love once obtained and there is also a tendency to respond in a jubilant or over-triumphant manner when such has been attained. "The same persons require that their heightened need should be to a large extent taken care of by the environment and behavior is characterized by oral traits." "In the depressive state process there are combined the striving to conciliate the patient's own super-ego and the persistent intrapsychic operation of sadism, directed against the introjected object. In mania this reconciliation has been attained and with it the elation that goes with the infantile self-regard."

III. Clinical Abstracts

Case One. Summarizing statement: This patient, male, age 43, was a mathematician, who was admitted in a manic attack after having been in a hypomanic state for over one month. During his first 10 days in the hospital he was definitely more overactive, overtalkative and elated. This was followed by a two-week period in which there was a definite break with reality, a break which was varying and was characterized by dramatizations, misidentifications, symbolic behavior and utterances. He then gradually returned to more normal behavior with a brief period in the transition marked by fatigue and general lassitude rather than by a recurrence of his earlier manic symptoms. This improvement was permanent and he left the hospital two months after this return to approximate normalcy. Attention is called to the two stages of his manic reaction of about 40 and 14 days each. This patient was interviewed from admission and his behavior and productions re-

corded at considerable length. He was cooperative and intelligent, and as he improved interviews covered on the one hand his retrospective account of his statements and actions, and on the other a detailed life history. Soon after his admission anamneses were taken from his wife, sister, brother, a fellow teacher, and a nurse of his childhood. As a result, a fairly complete life history was obtained.

Family History: This patient's grandparents reached advanced ages and died of usual causes. The father was a highly religious, austere, aloof individual, an Episcopal minister and teacher of Hebrew. He died at over 70 years of age of cancer of the stomach. The mother was a maternal type of person who had lost four previous children in their infancy and was therefore overprotective of the remainder of whom the patient was the youngest. An only brother, eight years his senior, had "spinal meningitis" at 12 and continued as a boy of 12 in many ways, remaining an odd, absent-minded individual who was never able to work but who was musical and quite a linguist. He was subject to severe temper outbursts, particularly during our patient's childhood. An only sister, four years our patient's senior, became a teacher, remained single, and assumed efficiently considerable and increasing responsibility in the care of the family.

CHRONOLOGICAL LIFE HISTORY

Age in years	*Events*
	A non-instrumental delivery; a "blue baby" born at eight months.
2	Nursed at breast two years. Weaned easily.
11	Slept with mother to this age.
4	Circumcision. His father gave him the chloroform; considered that his father was trying to suffocate him.
4-6	Betty, a childhood playmate (later contacts). Attended kindergarten. Recalled playing with blocks.
5	Given the book, Alice in Wonderland. Shown paternal grandmother in her coffin.
6	Noted difference in the two sexes.
6-7-8	Nightmares. He slept with his mother; the father slept in the room immediately above and paced back and forth late at night.
6-9	Attended a private school.
8 or 9	Poison ivy, severe, on penis. Kicked on penis by a boy. Sexually attracted to a female cousin (see later).

9	Confirmation; considered by him to have been too early. Surreptitious smoking. Mother told him about childbirth. Worried because he "felt no love" for his brother. Would tease the brother who would in a fury retaliate so that the patient would have to run away or suffer real physical harm. The situation was worst in years 12-15.
10-12	Grammar school. Average ability.
12 or 13	Interest in naval architecture. Lacked Latin credits.
1 on	Summers on an island constituting very happy periods in his life in definite contrast to remainder of time in rather drab home with two old maid aunts and considerable discipline.
14-18	Attended a private high school, taking a scientific course. He felt inferior since fellow students had nicer clothes and he was ashamed to invite them to his home.
15	First masturbation.
16-19	Nocturnal emissions of greatest frequency.
16	Began to get along better with brother. Became increasingly close to his father. Previous attitude of awe, reverence and respect for father continued. The patient's studies and boating in the summers were mutual interests.
18-19	Sept.-June. First year in N. Y. College. Maternal grandmother died.
19	At the usual summer place June-mid-July. Became loquacious, overactive, and talked of being called "rummy"; expressed fears of being "cut", and when taken to a mental hospital spoke of it as being a house of ill fame. Improved in four months after what was considered to have been a manic reaction of a manic-depressive psychosis. Was paroled. At the end of one month wanted to marry his female cousin.
20	Became depressed after his return to the hospital; began to improve in two months and two and one-half months after this he was discharged, essentially recovered.
20-22	Remained at home, missing college for two and one-half years. Received osteopathic treatments, tapering off in frequency two years; spent his time in walking, reading, doing very little else. The physical complaints, headaches and indigestion gradually cleared up. Was fond of this osteopath who was kindly and elderly. Considered at that time taking up medicine or osteopathy. Had previously liked the female cousin who was jolly and reminded him of his mother; was interested in the daughter of the osteopath for the same reasons.
22-26	Returned to the college, beginning with a light course; received B. S. degree at 26.
24	Called on and renewed friendship with Betty, a childhood playmate. She, too, had recovered from a nervous illness and was delicate; a platonic and desultory friendship lasting 13 years.

26-27 Taught September to November in a private boys' school. He left or was asked to leave after two months because he could not maintain proper discipline among the pupils. Then rested until the following February, and taught until June in New York City in a private school part time, working part of the time on an M. A. degree.

27-28 Spent the summer as usual on the island and that fall taught only a few weeks in a high school. He resigned because of disciplinary trouble, blamed on large classes. Says that he was "nervously tired out," "morbid," "despondent," that he had indigestion and was in bed several days.

28 Completed the work for his M. A. degree the following February.
Was drafted into the United States Army in early 1918 and honorably discharged one week later when his father intervened because of the son's previous mental illness.

28-31 Experienced his best period of adjustment and physical health, his work consisting of part accountancy, part bookkeeping.
He joined the Coast Guard Artilley and drilled regularly.

31 Father died of cancer of the stomach in June after a gradual decline. The patient exhibited no unusual grief or reaction.
Family moved into another locality because of old associations. Patient still desired to return to teaching.

31-32 The next school year he did substitute teaching, again experiencing some disciplinary trouble.

32 Met a teacher, Eva, during this summer and went with her a great deal for the next two years. She was attractive but quite aggressive and domineering. Her influence was responsible for his getting a job teaching in California one year later. Two years later she terminated the friendship herself.

32-33 Taught in a high school near New York.

33-35 Taught in a high school in California.
He was asked to resign for some unknown reason. Did some voluntary work in prisons singing and assisting in the services.

35-36 Taught for a year in another high school in California. Began work on a Ph. D. in mathematics which he has not yet obtained.
In March he had a difficult class, felt upset and despondent, and voluntarily took two weeks off, returning to work feeling much better.

36-37 Taught mathematics in a college.

37 Married a teacher after an acquaintance of several months. She was crippled as a result of osteomyelitis and many operations. His initial feeling for her was one of tender pity; she was a very narcissistic individual and has manifested a quite sadistic and critical attitude towards her husband.

31-38 Period of mother's illness. She died of cardiac failure at the age of 79.
No undue reaction to her death was apparent.

37-43 Taught college mathematics in the east.
His work was satisfactory. Continued work for Ph. D.

39 Birth of son, the only child; age four and one-half at patient's admission.

41 Disagreement with brother-in-law because of some business principles.

42 In May, four days prior to an approaching difficult examination representing part of the Ph. D. degree work, he developed gastrointestinal symptoms with "indigestion," gas, cramps and a depressed and anxious state of mind. Gastrointestinal and X-ray and fluoroscopic examinations in an excellent medical clinic were negative. The examination was deferred and he passed it satisfactorily five months later.

43 It was necessary for financial reasons for family to move into a cheaper and less satisfactory apartment.

Since marriage the financial situation has been difficult and the sister has contributed to the support of the family.

In October his topic for Ph. D. thesis was rejected after he had worked on it for several months. He appeared preoccupied and worried. This state of mind continued on until the appearance of hypomanic symptoms about Christmas, 1933. For the next six weeks (until February 22, 1934) he was in general overactive and overtalkative, with occasional periods of obscenity, carelessness in attire and overactivity. The definitely consistent hypomanic picture commenced about February 15.

Personality: He was of average intelligence, and small and frail in physique. He was a capable teacher of college freshmen yet had difficulty with high school boys. He was impractical, a poor manager, and showed little foresight in his plans. As a child he was timid and rather quiet, feeling physically inferior. He enjoyed non-competitive sports. He was a trusting individual functioning most efficiently in a kindly environment, with a tendency to become hypochondriacal and despondent in difficult situations. In his friendships he was attracted by people with similar physical qualities or with similar interests. He was overly sympathetic and spent an unusual amount of effort coaching the more dull students. His parents and sister meant much to him. He showed considerable sexual curiosity as a child. The sexual urge in his adult life was not strong. He tended to idealize women. His attitude towards his wife was protective and towards his son was a rather maternal oversolicitous one. He had a rather high degree of morality and was overscrupulous. Sexually and physically he felt definitely inferior.

Psychosis: This may be divided into two general periods of about 40 and 10 days each. The gradual onset occurred one month before admission. He became overtalkative and overactive. He

discussed family matters without restraint with strangers. He objected because his wife would not laugh at his risqué jokes, discussed her so-called "inhibitions" and he discussed sex a great deal. He also talked about religious matters, saying that his wife needed saving. A week was spent at a resort where he danced a great deal with other women and had his voice tested for radio broadcasting. He would not return home until early in the morning, in an unkempt condition, saying that he had been to night clubs collecting material for a novel. One week before he came into the hospital his physician curetted a suprapubic cyst. This incident was the source of several sexual speculations later in his psychosis. He was admitted to the hospital March 22, 1934. This general type of hypomanic behavior and pressure of speech continued for a week and was followed by a definite break with reality, a break which varied in amount and lasted for 14 days.

Study of Ideational Content

In accordance with the general plan in this study, the patient's ideational content was studied. In the survey of the psychotic period in its entirety one is impressed by the fact that there was a certain increase in the severity of symptoms, that is, there was an increased departure from normal as indicated by the basic symptoms, mental speeding up with flight of ideas, elation, and increased psychomotor activity. As has been suggested the symptoms indicated two definite stages. Each of these represented a distinct regression from that level of behavior which went before.

The aspect of regression will first be considered, since it is shown so well in this patient. Dooley[10] in her comprehensive case report traced this regression in a female patient through three phases: adolescent, childhood and infantile. These divisions, particularly the first two, seem to be demonstrated in this patient's symptoms. The first period began over a month prior to admission on March 22 and continued for 10 days thereafter. An indication of those symptoms prior to admission has been given. They were of a hypomanic character; they were of sufficient degree to make hospital admission advisable but not imperative.

Examples of the verbal productions will be first given which oc-

curred within the first few days of admission: "I've done promiscuous reading; I've browsed around especially in sex. You're married aren't you? My wife is devoted and passionate. I suggested to her that we do not make the thing monotonous but go about it in various ways." "I conceived of myself as two personalities—I think of it as being two circles—I love mathematics and everything is mathematics to me. I feel as if I'm two people, A and B distinct." "My father made the mistake of bringing me up too strictly. He told me of the danger of syphilis and never to have intercourse with girls but he never told me of masturbation. I had indulged in it before I went to H (hospital). I wonder if there was any connection." The patient's only previous psychotic episode was a manic-depressive one, both phases, at the age of 19, expressing fears about being cut, worry about acne, and being called rummy. He wanted, in his mania, to marry a cousin immediately. Returning to the productions, he mentioned his recollection of being circumcised at the age of four. "I recall my father holding the chloroform. I thought he was trying to suffocate me. The thought that he was my enemy persisted on through childhood. When he preached on Sunday I had a feeling of reverence but not love." Then the patient spoke of how much younger he had felt during the past few years, going on to state that he slept with his mother until he was nine. "I got too fond of her. My father did not think I should put my hands on her breast. I think my mother was too good to me. My wife is making the same mistake with my boy (age four and one-half)."

These statements of his all seemed to be in terms of early adolescent problems, and one felt that a definite regression had occurred and that the patient, no longer able to continue adjustment at his usual adult level, was attempting or had been forced to do so at a lower psychological level. The topics of his trend were the ones pressing him in his adolescence, namely sexuality, religion and life activities. Many statements were also concerned with the painful environmental factors associated with and antedating the development of his psychosis.

On Easter day, 1934, the patient received a chocolate Easter egg from his four-year-old son and this incident seemed to have initi-

ated a change in the clinical picture, a further and deeper regression comparable to that period termed by Dooley "the childhood level." He cried a little at supper. Several months later he gave these retrospective explanations. "At home we had a picture of my brother and sister who died of diphtheria before I was born. There was a certain facial expression in the face of Miss L. (a nurse) that was and is similar to that of my sister who died. The same was true as regards Billy (a boy of 12, a patient) and my dead brother. I cried at the table because I thought Miss L. was really my sister who had died." During the same night he was noisy and quite active, misidentifying everyone. The next morning this continued; he got into bed with his clothes on, expectorated on the floor and voided in the bed. About 10 a. m. suddenly he became rigid, with eyes closed, breathing deeply on suggestion but saying nothing. He later rolled on the floor, grabbing the nurses by their legs and becoming limp when he was put on his feet. He tore up his bedclothing and moved the furniture around. He was taken to a disturbed ward where he stared at those about him. Suddenly he grabbed the physician's watch chain and shouted single words, "universal," after a pause, "Catholic," then "universal." This was followed by short screams, apparently made up of incoherent words.

Thus began the 10-day period in which there was a definite break with reality. The details and various aspects of his productions and actions may be summarized:

First, he referred to various people including family friends and people who had caused him pain. He misidentified males, calling them his father, Bishop M., and certain friends of his childhood. He misidentified the female nurses as various girls he had gone with, and as his cousin. He would call the doctor by his correct name at one moment and call him Christ a moment later. He would also identify him as a friend, Campbell, who had teased him, or a friend, Donald, who had been killed in the war.

Second, he referred to various special events in his life, some pleasurable, some painful. These included his circumcision, pleasurable childhood experiences, army experiences, his confirmation, religious experiences, his previous illness at 19, and quarrels with his brother.

Third, he referred much to sexuality. His remarks gave rather definite evidence that he was insecure about his own sexual status, at least in his psychosis. There were sexual implications in his reference to Lewis Carroll's "Through the Looking Glass," and in his mathematical concepts. For example, he said, "Dr. S. punctured a little scab on top of my penis seven or ten days ago. It hurt awfully. Now what is that called, a dual personality?" Again, "I've had the idea a long time that man and woman are complementary to each other. He has testicles, she has ovaries, a sort of one to one correspondence. Can't a woman's left hand and a man's right hand correspond conversely?" "A woman is the mirror image of man" (after speaking of Carroll's book, "Through the Looking Glass"). He said later: "On the eighth (disturbed) floor I had some ideas concerning that callus wondering if it implied that I was an hermaphrodite. I thought the probing might have produced something analogous to the clitoris in the female." Again: "I have taken that carbuncle without trying to understand it."

The fourth group of the patient's ideas were of a religious character and concerned his father. His father had been a minister and the patient referred to having been anointed with oil in previous illnesses by his father as very remarkable experiences. He expectorated on the radiator cover and said (later) that he considered that he was depositing the sacrament at the altar. He referred to the passion play at Oberammergau, to Peter, and to the church.

Fifth, pleasurable childhood experiences were mentioned and dramatized. He had spent the summers of his early years on an island; in his psychosis would roll his trousers up, take off his clothes. He showed no embarrassment in front of a female physician, calling her mother several times. His attitude and symbolic behavior was childlike. Asked why he waved his hands around his head he said: "means spanking." Asked why he threw the slippers out of the room he said: "Oh, everything is insecure. I've always been a little afraid of my father. He never wanted me to have intercourse with women before marriage. That word intercourse denotes a one to one correspondence."

There appeared in this more regressive phase a wealth of symptomatology which was indicative of archaic or primitive thinking. He mentioned world catastrophe. He said: "If something vibrated across the earth, say you had a spiral spring, and it closed itself at the same time it widens itself what sort of a world would it be? If you get too many people on this earth and the earth rocks there will be an explosion." Again, "I have a theory that time must be going backwards. Some sort of comet must have hit the earth last night." Twenty days later he said, "Oh, I can explain my rapid gyrations. I recall asking if we hadn't hit a planet. My rapid emotions must have upset my equilibrium. I felt we were getting near some enormous source of power and that it wouldn't take much to blow us up and I recall thinking that if we had another world war it wouldn't be long until we'd be blown to bits."

There were references to electricity. He thought that the bed was wired and that it was to be a torture rack. He referred to perpetual motion frequently and gave it a sexual significance. He thought that the building was a house of ill fame and that it was mined beneath with dynamite. He said, "You woudn't have this thing (holding a cup) stay in this room. (He revolves it.) It winds and unwinds itself—it means perpetual motion." He was asked what was perpetual motion. "I think it is connected with the work of Satan. I think Satan stands for the lower nature of man." On the same day he said, "If a wire connecting with a diametrically opposite (he bends right knee to floor)—that means something very sacred. (Asked why?)—It is symbolic of intercourse. (He then bowed his head.) We seem to be in heaven. Where are the women gone? They don't seem to be here. (Asked, "Why do you bow your head?"). That's perpetual motion."

Thoughts of perpetual motion were certainly here associated with sexuality. It was sexuality that is expressed in motor activity that was displaced to the head, a displacement from below upwards. The archaic nature was represented by the projection mechanisms in that it was a natural phenomenon that stimulated him sexually. Sex was sacred and celestial. These sexual references had certain qualities; a cup was the work of Satan who was lower nature of man. The knee to the floor as in prayer, the reference to inter-

course as sacred, the implication that in heaven there was an absence of women meant to him the absence of sex.

Another type of archaic idea was illustrated in these statements. "I imagined that I was a tree." "I've wondered whether when a person is buried in a field whether the life doesn't pass into a tree." Later he said: "In that state I wondered if spirits of people didn't turn into a tree. I thought of the decayed matter underground and roots of trees. I thought in the process of dying I'd ultimately become a tree." At another time "I thought of the life of man and the life of a tree as a cycle. That is, while the tree started things, that after man dies he passes into the life of a tree."

While lying on a table he asked the physician if there had been a transfusion, spoke of anemia, of getting cold, and asked that his pulse be felt. He then lay quietly with eyes closed saying that he could not see. As he roused he asked if he had been hypnotized. He referred to himself as dying at Oberammergau, likening himself to the Christ. He considered the continuous tub as a coffin, became frightened and attempted to extricate himself.

The manic-depressive patients tend not only to retain their strong parental attachments but to reconstruct in their later life through their surrogates, the familial situation of their childhood. The later objects of their love interests tend to correspond closely to the parental picture.

May I trace briefly the facts as they occurred in our patient? The patient's first sweetheart was a cousin whom he saw frequently during childhood and whom he wished to marry in his manic episode at 19. At 22 he became interested in the daughter of a kindly osteopath. This girl reminded him, as did Agnes, of his mother. The osteopath acted as a kind father to the patient and for a period he considered going into osteopathy or medicine. Concerning these two girls he said, "I was infatuated with Agnes, the first one; she was clean-minded, natural; she was like my mother in that she didn't take life too seriously; rather stout and full of fun." "Miriam (the second girl) too reminded me of my mother. She was also full of fun. She didn't have the same kind of eyes. She had the same general features."

At 24 he again met a girl, Betty, with whom he had played at the summer home when he was about five years of age. She, too, had recovered from a nervous illness and their mutual interests were intellectual. They saw each other occasionally till he married his present wife, 13 years later.

The next affair occurred at 32, with an attractive, domineering teacher, lasted two years and then was broken off by her.

He eventually married, at 37, a crippled woman for whom his affection was at first mixed with pity. She turned out to be a rather narcissistic individual and was very sadistic and critical towards him. She was jealous of his attachment to his family and he was in turn jealous of her attachment to her family, making for an increasingly uncomfortable chronic situation which played an important part in the development of his psychosis.

The next statements demonstrated the importance to him of his parents. "My mother has meant a lot to me (he sheds tears). She was too good to me." "I got too fond of my mother. Father did not think I should put my hands on her breast." The next quotation is more lengthy and came spontaneously after he was asked what some of his manoeuvres meant. "I was dramatizing the Passion Play. Something happened to me April first (this was April sixth). They pretended I was put to death. At the same time I solved a certain problem in mathematics (he meant the knot problem with which ritual he claimed to have extricated himself from the continuous tub). I'm totally blind I think. Long ago I was told man and woman are exact counterparts. I was told my mother was a very fine woman. She told me a man's penis corresponds to the sex organ of a woman right above my penis. I had an infection there before coming here and Dr. S. used a piercing needle. . . ."

We have already referred to his attitude towards his father in childhood as one of ambivalence. He described nightmares with ogres at the ages six to eight which he associated with the noise of his father walking about in his study over the bedroom in which the patient slept with the mother. In the patient's early memory of his circumcision he felt his father was suffocating him. He referred to it as a trick in which his father played him false. He mentioned the rarity of the air; again he said that it was very im-

portant to have air. There is a strong suggestion that this suffocating particularly in connection with circumcision meant castration and that in some way it meant the death of his parents. Certainly the incident functioned as a trauma the recollection of which has recurred in his psychotic ideational content. He said once that his parents died when he was four, another time that his father died when he was four or five. He spoke of poisoning on the penis at nine, of being kicked on the penis at nine. In his episode here he would turn his back to show that he wasn't afraid of the physician. Once he said, "Go ahead, do anything you like. I'm not afraid of you; only don't hurt me in any way, especially down here (touching his scrotum)." He tended to ascribe unusual power to his father. His father once told him not to go out rowing when it was clear. In a few moments a squall came up. He said, "I obeyed my father implicitly whether I understood him or not."

These examples of his productions, really free associations concerning his parents, seemed to emphasize first that his ideas contained much of sexual significance and second that quite important in his mind was the kindness of his mother and the severity and more latterly in his life the kindness of his father towards him.

In his psychotic productions one noted many remarks concerning masonic order, fraternity initiations, brotherhood of man, a twin, and a mate. He went through various rituals to show that he was not afraid. He told those about him not to be afraid. He spoke of his brother-in-law as a white slaver; and would sometimes speak of him in the highest terms while at others he would revile him and call him a crook. These might constitute evidence of his latent homosexuality.

He said concerning his moving from one location to another, with considerable feeling: "All my life I've been having to give up one friend after another." His friendships with certain fellow teachers were exceedingly close. He enjoyed teaching and spent an unusual amount of time coaching backward students. His work therefore offered for him an excellent and satisfactory means of sublimating his homosexual tendencies.

We have therefore an individual who has been unusually narcissistic, manifested a strong sublimated homosexuality, and whose

love objects and attachments have been unusually closely related to the original family circle. The productions themselves gave evidence of these statements.

Case Two. Summarizing statement: This patient, male, age 23, Hebrew, a law student, became mildly depressed in the spring of 1933 and remained variably depressed until July. At this time he developed symptoms leading to an appendectomy. His general picture thereafter changed to one of normal interest, then to excessive interest, activity and elaborate plans for the future. He entered into plans with a friend to open a restaurant, used up his savings, became increasingly overtalkative and insulting, and was admitted to the hospital, October 26, 1934. There his overactivity continued, he became more irritating, wrote incessantly, and after three weeks became more sullen, assaultive, and showed more definite regressive features. In this state his productions revealed particularly well his psychosexual conflicts. He also made statements concerning father, God, power, sun, electricity, emanations and sexuality, which made their psychological meaning in his particular case rather clear. He was removed from the hospital three months after admission unimproved.

Family History: Hungarian Jewish parentage. The father, age 51, of peasant stock, came to the United States as a young man, working first as a carpenter, later did well in the real estate business and suffered considerable reverses in the depression of 1930. He was trustworthy, thrifty and responsible, caring well for his family; at the same time he was irritable and oversolicitous. The mother, age 49, also of Hungary, was rather flighty, improvident, and superficial. The patient was reared in a home atmosphere marked by tension and quarrels between the parents. One sister, 21 months his senior, was killed at 11 years of age in an auto accident witnessed by the patient, who was eight.

CHRONOLOGICAL LIFE HISTORY

Age in years	*Events*
	Birth: second child. Easy, non-instrumental labor. Breast fed six months. Sat up at six months. Walked at one year.
5½	Otitis media. Recurrent discharge thereafter. The family moved to another neighborhood.

6½-8½	Two or more incidents of sexual play with sister who was killed later.
8½	Death of sister in auto accident.
	Witnessed by patient. A serious trauma to him. The family moved to another neighborhood because of old associations of the deceased sister.
10	Put in open air class because he was frail, anemic, and had frequent colds. Didn't enjoy school.
8-10	Father began urging patient to become a lawyer. The patient did not think much about it. He was taking violin lessons to please the family but was disinterested, keeping on to please his parents. The patient says, "I was a very good kid, very obedient, did all father told me; I did lots of work for mother about the house, dusting, washing dishes—"
13-14	Enjoyed himself immensely in summer camps.
14-18	High school.
15	Intercourse per anum with male cousin; fellatio shortly thereafter. Felt disgust at latter.
17	Shaved for first time.
17-21	Attended university at a distance from New York. Graduated. Arts degree. There he "ran a little wild," associated self very actively in fraternity affairs, visited prostitutes occasionally; school work was mediocre.
	At least one homosexual affair. Spent money rather freely; showed very little concern when reprimanded. Was overly interested in a course in abnormal psychology. Little or no alcoholism. (This general behavior pattern covered the four-year period and partook somewhat of the hypomanic character.) There was a mildly depressive period of a few days in his junior year at age of 20.
	Resented his father's insistence that he take up law, and was mildly interested in journalism.
21-22	October, 1932 to June, 1933, attended law school in New York City after considerable persuasion.
22	Summer camp, 1933. Sexual matters were topic of general interest and conversation.
	The patient thought he was considered girlish, peculiar; he felt isolated, inferior, unhappy and restless. Mild depression began.
22	October-December. Attended law school. Work unsatisfactory. Asked to leave. Depression increased during this period.
23	January-May, 1934. In two mental hospitals except for a period of improvement in March. He was normal during June and July.
	Appendectomy in early August. Returned home, August 19, 1934.

Personality: Average intellectual level, frail physique, sensitive, overprotected, attached to and pampered by his mother; paternal attitude one of oversolicitude. He was a quiet child, played freely and protected by his father in fights. A finicky eater, a fastidious dresser. No religious interests. Childish sexual play with

sister and adolescent homosexual experiences. Heterosexual experiences but no love affairs. He remained essentially narcissistic and homosxual. The feeling of physical and sexual inferiority was pronounced.

Psychosis: Shortly after August 19, 1934, he became impudent, tactless and insulted everyone. He entered into the plan of opening a restaurant, lost his savings of several hundred dollars, became increasingly excited and talkative. Three days before admission he became really psychotic. His attitude towards his father changed in that he was no longer critical of his father but said that he was "a swell guy" and would help him out of his difficulties.

Study of Ideational Content

In a consideration of this patient as in the first case, the patient's verbal productions constitute the source of material. The same ideas were expressed again and again, and ideas had to do with father, mother, the physicians, life work, need for love, sexuality, and involve to some extent symbolic and archaic expressions.

When the patient was asked his name, following admission, he gave it, adding "Son of the eminent (naming father), if it's all the same to you. I came here on the old man's advice, the best man that ever lived. I'm convinced now the things he's been telling me all my life are good for me. So I found there was no place like home—just so I'm convinced that learning from other people is the thing to do. Of course my father is another people. I can learn from him. Like father, like son." Again: "The old man's all right. He's the one I love and revere, but he is awfully irritable."

He said concerning an occupational therapy worker: "She emanates a good deal of sexual attraction, a kind of motherly person. I came up against the same towards Miss M. (a nurse), but I never associated it with any evil thoughts because I associate her purely with my mother."

He was asked how he felt towards his mother. He replied, "O. K." He was then asked if he had hostile feelings towards her. "Yes. She used to say, 'Kiss me as my mother would.' This was when I was depressed. I didn't want to kiss my father, just to shake hands with him. When I kissed my mother it was maternal

but more. It would have been better if she had kissed my father that way, reserved those kisses for him. It is interesting that now she keeps her tongue to herself. She keeps her mouth shut and doesn't kiss me as much." He said, in response to further questioning, "Her tongue protruded somewhat." "It was extremely unpleasant." "It was a sexual kiss." "I would kiss her a quick dashing nip across the lips." He was asked if that were unpleasant. "Isn't it easier to leave that unanswered since it was between mother and son? It speaks for itself."

He spoke of singing and was asked how he felt when he sang. "Maternal emotions. My mother was very depressed when my older sister (who sang well) was killed in an auto accident." He was asked what traits stood out in each parent. "My father has the good brain, my mother has the good heart."

He seized the lapel of the nurse's coat one day and insisted on making this statement: "My father and mother haven't proved they are my parents yet. Do you think my father looks like me? He makes up his face when I'm not around to look like me. I do not believe he is my father. I do not believe my mother nursed me. That is why I am here."

He had been speaking of his parents' recent visit. "Yes, the visit was very nice. Dad seemed just a bit under tension but mother seemed comfortable. Father was envious of me. It was an old habit of mine. I would pop into the bedroom or lie on the sofa alongside of mother, or in between both of them. I never had an evil thought, never once in my life. I tell you I never did, even when he wanted to kick me out of the house. I hope this is not unjust, but he is jealous and envious of my education. In that same bedroom he wouldn't listen to my advice about a contract. He doubted me."

The patient's attitude towards his parents seemed much more puerile than one would have expected in a man of 23. The ambivalence to both parents is obvious, but his relation to his father seemed to have particularly expressed itself in his psychosis. The ramifications of his relationships to his father extended to productions to be given shortly having to do with a vocation, with God, with the physician, and with other men.

His attitude towards his father a few days before admission became a passive one whereas before he had hitherto been assenting himself or trying unsuccessfully to assert himself against his father. During his adolescence he did things his father wished against his own desire. He studied violin and he took up journalism. He very definitely avoided too definite a stand against his father. He invoked his father's support when asked his name: "son of the old man if it's all the same to you." He easily included the physicians and even others in the rôle of his father. He said that there was no place like home, that his father's advice he at last admitted to be correct, that he was convinced that learning from other people was the thing to do, and immediately said, "Of course my father is another people. I can learn from him." This ideal father was a kinder and more powerful father than the one he described at other times in his resentment. This father differed from his conception of his father prior to his illness. In his psychosis his father tended to approximate his inner conception of what constituted a perfect father. The same applied to his father substitutes, the psychiatrists.

The same applied to his picture of his mother though he did not have much to say about her. There was evidence that towards her also his attitude was one of ambivalence. His only reference to hostility was associated with the idea of her kissing him. Such statements as "it was not maternal; it was better if she had reserved those kisses for him (father); it was extremely unpleasant; it was a sexual kiss" were strong indications of a retrospective falsification in one with so much tendency to project. There was strongly implied the sexual attraction of the mother and a full realization that such was not proper for a son, but was proper for the father. On another occasion he spoke of irritating his father by crawling into bed as a child between the parents. He spoke first of getting thus into the bed and then added that this occurred on the couch. The patient had thus in his productions indicated the Oedipus situation rather clearly. He has also indicated a rather strong reaction to this Oedipus situation. He projected the blame for a substitutive sexual act, a kiss, onto his mother. This seems to offer an explanation for his attitude to his father. He refused to go too

far in playing the father rôle. He took a passive attitude towards his father, towards the physician, and towards men. This was seen in his productions concerning physicians and homosexuality. "I absorbed as much of this energy as I cared and when I had enough I'd shut it off myself. I didn't want to compete with you."

It must be pointed out that these productions occurred in an individual showing a moderate and variable degree of regression. His mind was concerning itself with the very same questions which were presenting themselves in his childhood. The level of his psychological regression is indicated as approximating that of the latency period.

How does his history show that the Oedipus situation resolved itself? He dismissed the discussion of the unpleasantness of his mother's kiss by saying that it was a question best left unanswered since it was between mother and son. There were no actual love affairs in his life. He had had sexual intercourse a few times with prostitutes since entering college. His emotional ties outside the home had been with men, with overt homosexual experiences with a cousin and with a carpenter (his father's profession). These were accompanied by a certain amount of conflict. In this hospital he was often paranoid in that he thought other patients were going to assault him sexually.

There were many verbal productions having reference to homosexuality. A few days after admission he said to the nurse at a mixed party that he could not dance with the female patients because "I would lose my virginity." Referring to his sexual experiences with prostitutes while in college he wished it understood that he had "taken it straight" except once. Fellatio was performed upon him and he says that he felt disgusted. In an interview one month after admission he walked to the window saying, "I let that one out." (He was asked what.) "A fart." (Where from?) "The rectum." (What else comes from there?) "Shit, feces." (What about that?) "I wouldn't eat it." (Why not?) "Smells, can't be healthy. It's waste. Let's see. It's bodily refuse. The poisons are in it. Maybe it's like ash. I'd swallow ash, like water. Feces, crap, know the saying 'I wouldn't take crap from you.' The thought that comes in my mind is that maybe I would take crap

from you." "I was playing cards today. Brooks and I were partners. We exchanged motions, he crossed his leg. I suddenly felt that give (pointing to right groin). It seems that my left eye is a little sharper than my right." He said that he saw a reflected gleam of light from the nurse's eye, received in his own eye, and felt as a twinge passing from the left eye to the right.

The word "sexual" was given as a stimulus to his productions. He immediately began: "That word has popped in my mind so many times and in my thoughts, in thoughts yes, but not in my emotions. At L. there was the sweetest carpenter. He had been a real good man. He gave up cards and everything. He was very kind—he invited another fellow and myself." He stopped. Then asked about this sexual feeling. "I would like to give it to him. I would like to love him and have him for my own. Look here, isn't that funny? I am not sure whether I thought that way. I feel as if I'm a man right now; it's a pretty good feeling." He was asked what was this feeling. "Let's not discuss it. It's emanating from you." He then heard a bell. He spoke of songs, of a girl, of how he sang when depressed. He was asked how he felt when he sang. "Maternal emotions. My mother was terribly depressed when my older sister was killed in an auto accident. She used to always listen to her voice, a beautiful voice."

In these productions there was some evidence that he was insecure as regards his sexual status and that he identified himself to a certain extent with his mother and with the deceased sister who was killed in an auto accident when he was eight. He liked singing; his sister sang well. When he sang he felt maternal emotions. His next remark concerned the sister. There were frequent references to his eyes, particularly the left, "weaker eye."

There was in this patient's psychosexual make-up a large homosexual component. His heterosexual development was possibly thwarted rather easily by the incestuous experiences with his sister at seven or eight, by the failure to resolve the Oedipus situation, and by his adolescent experiences with reality. His attempts to make good at school were directed towards establishing himself as a person not inferior to his fellows. His homosexuality and narcissism were clearly indicated.

The relations with the physician were shown in these remarks: "Your word goes. I'm here to learn and you can teach me." "You're top man here. When you closed the door I felt impelled to rise." "I want to follow out the routine, be a human being, to be a doctor. My actions prove it." He referred to the secret power of a doctor, "the power of healing." "I just can't help giving patients psychiatric advice and it gives me a headache. I know the impulse comes from the nurses." "Two patients have improved from it." He opened an interview by launching a discussion of medicine and of his desire to be a doctor. "I want to be a doctor, to study medicine. I want to acquire the physical habits of a doctor. The mental part will come later." "Well, let's get serious. I've searched and searched and I've found it. Medicine. Psychiatry. A life career."

The following excerpt is taken from material the patient wrote under the title "On the Evolution of Mankind": "It is not of vital importance that one be ambidextrous; that is, to be able to use both the left and the right hands with equal facility for a task or an act such as holding a ping-pong paddle or pencil. However, it is essential that a human being, for the sake of convenience, more in order that the enlightenment of mankind continue its progress to a more civilized and sympathetic and unbeastly plane should develop and use every instinctive and acquired faculty in his or her chosen life work. It would follow, then, as a matter of course, that each individual during the life span would be making some contribution to the advancement of science as well as to the betterment of the human race as a whole. The reason for this onward push of man lies with his desire to adhere to the will of God and to synchronize his movements (or actions) with those of bountiful Mother Nature, as none of us on this planet understand her and her machinations. To solve, probe, discover, analyze, peer, seek, search, learn, see, look, gaze, and adhere to an accepted standard of morals or behavior; to make adjustments to an ever-changing, unrelenting universal environment in which the stronger survive and propagate their kind is the theory which leads to an unperturbed and useful existence. Usually the individual is able to reap sufficient rewards in the cur-

rent medium of exchange for his services from his fellowman that is enabled to provide for wants and luxuries."

He once remarked: "It occurred to me that if I kept playing around here and acting the rôle of the boy that wants to be doctor I'd be doing it all my life." "I am very strongly attracted towards men. Right now I think you have a very powerful personality, not the sexual kind, not the kind that you like to sell people, like electricity, and gets money in return, nor like political power. You don't want to be President or Governor. It's just psychiatric power, a secret power. Right now I see you do that (the physician had moved his hand). As a matter of fact it relieves a little headache on the left side. It's that power, that power of healing. That's why you're a doctor."

He wished on the one hand to be a patient and on the other to be a physician. He ascribed to the psychiatrist special powers of healing. It is felt that the physician represented a father surrogate to whom the patient ascribed kindliness, benevolence, and altruism.

The patient also identified himself with the psychiatrist. He would have liked to be one. "I've searched and found it, a life career, medicine, psychiatry." He could not help giving psychiatric advice to patients. Even here he dared not usurp the psychiatrist's rôle completely. He projected and said that the impulse came from the nurses. He was moderate in his claims when he said that two patients had improved under his treatment. "I absorbed as much of this energy as I cared and when I had enough I'd shut it off myself. I didn't want to compete with you."

The attitude towards marriage was shown in his remarks concerning the female physical supervisor, Miss B. (the Miss M. referred to was a nurse, Mr. B., a male nurse). "I've had very fond thoughts of Miss B. I imagine we might be married, that Miss M. and Mr. B. (nurses) whom I like, could be married, and that the four of us might some time in the future all sleep together; a married relationship established in my mind between the two couples. Since variety is the spice of life and all are nice we'd have a party and sleep with the other person's wife. It was slow for me to accept all these imaginations. Adultery is out for me but the human

race or science might benefit from it and the compensation to us would be that we would enjoy some of the pleasures of the flesh. For me actually one is enough, one God, one woman. That's the Jewish and the general moral tradition."

He said that he was attracted to Miss B. because of "her discipline, her injunctions to sit and stand erectly, and her clean, pure mind." His father had emphasized discipline and good posture in the home, which the patient had resented and criticized.

Attention is called to the point of view towards marriage. He described a heterosexual situation in a homosexual setting, with the elements of sharing another man's wife and having his wife shared by another man. His contact with reality and innate appreciation for the need of justification of such an idea is seen in the remark "adultery is out for me" and seen in the rationalization that science would benefit while they enjoyed some of the pleasures of the flesh. One sees here the ease with which altruism entered.

The narcissistic need for love from parents and from the environment was shown in two examples of his productions. He seized the lapel of the nurse's coat one day and insisted on making this statement: "My father and mother haven't proved they are my parents yet. Do you think my father looks like me? He makes up his face when I'm not around to look like me. I do not believe he is my father. I do not believe my mother nursed me. That is why I am here."

He was asked what about man's feeling towards his own sex. "One of help. It's a selfish world. The radio here was turned on this afternoon to give us psychic treatment. It was patriotic music and patriotism means something to me. I want a wife and family. Here I've met people uniformly kind and good. I long for association of this kind." (Why?) "Because they are sincere, clean, laugh at the right things, and can take their own medicine. All my life in my home I've never been allowed to lie back on the sofa. It irritated my father. We had to sit up straight. He once gave me a calling down, before some men, for lounging. I'll never forget how humiliated I was."

The doubt expressed concerning his parents was subject to two interpretations. The one, that he was not their son but was of divine origin, did not seem impressive. Rather, in view of the setting and of his antagonism to the parents at that moment, it seemed that he was rejecting his parents because they had not been good parents to him. He started out by making himself the judge and directing his thoughts towards the parents and their attitude towards him. He doubted that his mother nursed him and said that was why he was in the hospital. (This reference to nursing should have been followed further.) There was certainly an oral attitude which is so characteristic of the manic reaction.

In the second illustration two points related to the narcissistic need for love are to be pointed out. In the first place, he expressed a desire for a wife and family. Then he went on to point out how the hospital had furnished an environment he would like, one characterized by people who were kind and good, sincere, clean, who tolerated him, that is, laughed at the right things and could take their own medicine. Then he gave an example of how his own household interfered with his comfort and ease. One concludes that the new home situation he would have liked to establish would have reproduced the original perfect home, centered about his narcissistic needs. In the second place there was an indication, in this instance at least, of what patriotism meant, and here several other references gave a similar indication. Patriotism gave him a common bond of identity with his fellow man. He said that this was a selfish world and that man's feeling towards his own sex should be one of help. Patriotism is a form of social emotion, the idea concerning which in this instance had its origin in the patient's need for help and kindness.

The account of the depressive period which preceded the manic attack was discussed at times with considerable insight. The following gives a retrospective account, as he saw it, of the transition from depression to mania. "Last October (when he was depressed) I felt funny feelings in my eyes. A change in the optical nerves was taking place, a rotting. I just felt myself rotting and decaying away, a sort of change in the nerve structure causing tension. I'd walk about and feel the cerebral hemispheres go bing.

I was having headaches. Then suddenly I came out of it. There was a reconnection. The nerves of the eyeball were reintegrating. I've been drinking a lot of water. That helps the nerves. At that time I felt the segments of the brain were piecing together, emotionally speaking. I felt just good, not exhilarated, mind you. There was a religious experience." He quoted a long passage of Hebrew from the Talmud. "At that point I was thinking of 15 things at once, of father, mother, God, baptism, revelation, a sort of rebirth." He stopped. He was asked what his early religious experience was. "Well, the climax should have been Bar Mitzva (word for Jewish confirmation) but it was not. I felt important and nervous. The rabbi buzzing in my ear bothered me. I knew the thing by heart and I wanted to give it out. I was nervous rather than sincere. The people in the synagogue didn't know how to instill religious feeling."

The somatic delusions of rotting and disintegration were referred to in a manner which has been described by other patients. But here there occurred also a continuation of this somatic process in which the nerves of the eyeballs, which had been rotting, were felt to be reintegrating, and the segments of the brain, which had been felt to go 'bing,' were felt to be piecing themselves together "emotionally speaking." He then described a religious experience. It must be realized that these were spoken thoughts occurring in a preoccupied mental state. The phantasies of that moment were of psychological importance despite the tense in which the statements were described. What seemed to have been expressed was a religious experience involving rebirth and reincarnation. His reference to his impression that the rabbi was buzzing into his ear and that he, the patient, knew the content by heart and wanted to give it out seems to offer a parallel to the attitude of the manic patient to those about him who usually constitute authority and who function in the environment as authority (such as the rabbi). The patient virtually said that he was not listening but that he was the one to be listened to.

There were a number of ideas which tended to occur together in a similar setting. They were produced when he was somewhat confused, more incoherent and tended to mutter in a low tone of voice,

and was in the continuous tub. These remarks referred to east and west, to his sister's death, to coldness, heat, the sun, new life, energy, and glands.

He was reminded of his reference to electricity on the preceding day. "East is east and west is west. Never the twain shall meet. Perhaps I can come to it from that point. Oh yes. It may have been a matter of glandular disturbance all around. A man can pull himself up by sky hooks, that is, if he has the right kind of imaginations. It other words, I forced myself to really meet people."

"Leaving the train I saw a girl who was a honey." He had been telling about how he felt at the latter end of his recent depression. "I was considering the Atlantic City gag or whether to go back to study (for examinations) when along comes a nurse with a baby, a warning obviously. Well, one of the girls turns east, the other west, leaving me gaga. So I decided to go east, young man, and went up East —th Street to a friend's apartment where I got relaxation."

There was a night in which he faced east, facing the sun and absorbing its energy. In connection with facing the west he said that it was in dim, dead winter, that nothing happened, and that he went to sleep.

He was whittling at several pencils and said: "Ah! a penis symbol. There was a bunch of bastards once who indulged in penis worship, wasn't there? Primogeniture. They wore themselves out. Egyptians. Well, there was a window—faced east and west —girls looked out, attractive—what was that thing the Jewish rabbis used to put over their head in the morning?" He was agitated, twisting his hands, muttering something about phallic worship.

"I was born on Third Avenue—that street ran north and south, and you know that misfortune occurred on the streets that ran east and west, where my sister's accident happened. Oh the hell with all this symbolism." He was referring to the death of his sister, said that their relationship was almost like being wedded, that his was the wrong kind of curiosity, seemed agitated and banged his hand on the table saying, "It's like sparks flying off, subconscious memories that caused me pain, not pleasure. It's better that I do

this. I'll be the medium through which my mother and father will be absolved."

While in the continuous tub and quite excited he included the following in his remarks: "I can't begin to describe how I feel. Every minute I'm responding to a certain definite stimulus. When I studied law I disregarded life and lost my sexual appetite—lived like a senile man. I was tied up, muscles rigid. Now I'm all loose and limber. Shall I study medicine? I want an aim in life, a goal. Movie actors bask in the sunlight. There's only one light I like—" "One night I was much disturbed. I went through a God-like complex, something like Porteus out there facing the east. I was expecting you to come in and ease me off this floor to another where I wouldn't be compelled to go through all these gyrations. I was out in the hall. I was expecting something to happen. It was dim, in dead winter, facing the west, nothing did, and I went to sleep." He was asked why he felt God-like. "When I was absorbing all this energy I felt like Ra the Egyptian Sun God. I had the feeling that perhaps you were sun worshipers, and that I was being initiated into it. I was facing the sun and I was absorbing energy." Asked if there were any changes in his body, "I'm stronger, I know for a fact. My muscular development is improving." (You were chief of the cult?) "I was being initiated. Other patients were not aware of it, not intelligent enough. I mentioned Rosicrucian, the brotherhood. I've seen the ads, a nuptial religious cult. At that point, one week ago, I felt very sunny and elated. I almost became God in my own imagination; it was the closest I ever came to being God. I felt (then) as if I were just bursting. The energy, my own glands, were functioning too rapidly and throwing off too much energy in myself. It was a feeling not unlike pain with headache and a very tired feeling. A blotter like this, red, white and blue, stimulates one to tell you all these things."

This patient would start out with a statement which was not understandable and change to a statement that was understandable. For example he said: "It's like sparks flying off, subconscious memories that caused me pain not pleasure." The symbolic meaning to him of east and west remained partly unclear. In certain

instances facing east was associated with facing the sun and absorbing energy.

A certain group of ideas which this patient presented were connected likewise with his more regressed state. They concerned electricity, emanations, radiations, a power house, the faculty of absorbing and repelling. "I feel charged full of funny electric current. I've been going through with funny motions having to do with charging and discharging positive and negative poles. For example, something happened here (he points to his genitals) today." He then referred to the bells which were ringing, to an American star he was making in occupational therapy class, to an obsessive thought "kill that guy" which varied, to patriotism, to his father, back to the therapy class, then after a pause: "People interfere with the triangular cross currents that seem to originate from the sun, which emanate or radiate to those people and are stored in the earth in the form of heat further down. Beside that internal core of energy there is still that energy from the sun that is lessening every year. I had the idea that the ice caps come and cool things off, because of the deviation of the sun. The only surviving beings on this globe, the ones that would survive in that cold, almost frigid, like a vacuum. There would have to be built up for each human being a shell to protect the beings. I put Archie to sleep talking like this. Sex may enter in." "I'll get even with the environment. Maybe I'll do some radiation for a change. If I'm going to study psychiatry and get married, I'd marry Miss B." He was asked what gonoid meant. "Gonoid, here, may be my appendix (which had been removed). My Jewish heart if they want it." He attacked another patient one day, a combat resulted and as the two were separated he shouted, "I'll castrate you." In the continuous tub a moment later he said, "This isn't a sex bath is it? It's an electric bath."

There are here given a series of successive statements referring in order to bridal night, homosexuality, copulation and rebirth: "Let me tell you about last night. Cooperative imaginations. Lying on the cot in the sitting room I thought the toilet in the nurse's office was a power house controlling the lights in the sitting room. There was a connection somehow between the power house and

myself. I was talking to Mr. D. and Mr. P. (two male nurses who were in nurse's office) somehow, by electricity, I guess—which reminds me, on the other ward I thought there was a two-way radio set, a two-way condom, in my right ear, so to speak, that carried messages, the energy was supplied by good old chlorophyll, the original source the sun. There was a discharge of the negative electricity and receipt of the positive. Well, where was I? Oh yes—" He referred to going through all the motions some of the male nurses went through, "all except the climbing up"; he was reminded that he wanted to marry a nice girl, a Jewish virgin, he phantasied "the bridal night." He spoke of getting the right posture, of an electric spark from the bedspring and then he went on to give an account of two homosexual incidents at 15 with a male cousin which, he stated, he had never before revealed. He then went through a number of bizarre postures which, he said, the male nurse had recommended, then turned to the wall, legs wide apart in a copulation posture. At that moment he complained of a kink in his ankle. He then curled up on his side in an intrauterine posture. He stopped this abruptly saying, "No, that's dementia præcox, rebirth. I had the feeling of rebirth running through my head." He was asked to associate to the word "absorbing." "L. uses foul words. I don't absorb them. They sort of bounce off. Whatever you say to people here I try to apply to myself. If it's good I absorb it, sort of fortify myself, and if it is bad, discouraging, I ignore it, or try to."

The manic patients often refer to "mind over matter," "positive and negative" and other bipolar forms of expression. The reference to electric current and to charging and discharging positive and negative poles was immediately connected with his genitals. He referred to the continuous tub as a sex bath, then as an electric bath. The right ear had been having recurring discharges since childhood and his hearing was impaired. He spoke of a "two-way" radio set, (meaning, one must suppose, discharging and receiving) and immediately shifted to a "two-way condom." The ear to him had a bisexual function and was undoubtedly a symbol of the female genital as well as the male. One sees the utilization of an inferior physical organ, the ear, in a displacement from the genitals.

There was an indication elsewhere that the eye was similarly used. He used the term electricity and at the same time was sufficiently in touch with reality to use another symbol of a higher type, as the ear, or refer to the genital itself, or to gonoids or glands. The energy was said to have been derived from the sun. The primitive thinker does not concern himself with scientific explanations. The patient, as his associated manifestations suggested, was not quite so deeply regressed. So he put in a somewhat scientific explanation in adding that "the energy (for the messages) was supplied by the good old chlorophyll, the original source the sun."

The means by which good or helpful words were absorbed and bad or discouraging words were ignored seems to be an excellent illustration of the mechanism of denial. This was described by Ferenzci.[16] who stated that the earliest means of the child for facing unpleasant situations consisted in ignoring them. The patient says that if someone used foul words, "I don't absorb them. They sort of bounce off"—and again, "If it's bad or discouraging I ignore it or try to." This is another corroborative bit of the evidence pointing to the facility with which he rejected unpleasant ideas.

He made the statement, "I'll get even with the environment. Maybe I'll do some radiation for a change." This seemed to be along the same line as his wish to be a doctor. The inference was that the world had not treated him well. The attitude of the manic ego to the world seems to differ from that of the ego of the well individual. Here he implied that his was a revenge motive, that he would in some sadistic manner get even with a world that had been unkind to him. The fantasy that the energy from the sun was lessening and that the ice age was approaching was followed by an excellent description in his own words of a return to a protected sexless state comparable to the intrauterine state.

This patient, in brief, exhibited a considerable degree of regression. His ideational content indicated that he had remained largely in the narcissistic and homosexual stages of his psychosexual development and that he was overly dependent upon kindness from his parents and others.

IV. Critical Observations

The point of approach here is a psychological one which employs the symptomatology and ideational content of the manic patient for the purpose of determining the fundamental difficulties on the one hand and explaining the symptomatology on the other. A review of the literature, and common sense as well, seemed to indicate that until a better and more generally accepted understanding of mental mechanisms and of behavior had been reached, the rational method of approach would be through the use and study of patients themselves and of the facts which they have to offer us in their statements and behavior. The time may be reached when the facts which deserve emphasis can be expressed statistically but for the present the most rational and practical approach involves first concentration upon the understanding of individual patients. This seems sufficient justification for the presentation of two patients in a rather summarized manner. Only certain of the aspects which they demonstrated are elaborated upon. A communication of this scope could not follow up all the leads for further investigation which the patients have given us.

The method of study of the symptomatology was uniform. The verbal productions were found to fall into certain broad groups. These groups were alike in these two patients and seem to be alike in other manic reactions. The ideas which manics express constitute, as Campbell[8] emphasized in 1914, a guide to the patients' conflicts. Not only this, but as the subsequent list indicates, they furnish us a guide to the symptomatology at that moment, for example, to the regression with all its associated phenomena.

The ideational content fell into these groups: 1. Ideas referring to the rôle of the parents; 2. Ideas referring to psychosexual growth; 3. Remarks concerning environmental objectives; 4. References to psychic traumata; 5. References having to do with death and rebirth; 6. Remarks indicative of symbolism, modern or archaic.

The initial step in analyzing the items to which the patients referred consisted in enumerating these items as they appeared in the case record. It was found, for example, that in the first patient there were 112 individual items included involving a total of

353 references. In the second patient there were 53 individual items with a total of 123 references. The longer number in the first was due to the fact that observations extended over a longer period and covered almost one year following recovery. This patient was usually communicative and in his regression referred to a variety of topics of an archaic nature, a general field that was touched upon to a much lesser extent in the second case.

The number and scope of the references of the ideational content are not of so much psychological significance as the emphasis which was placed upon certain topics.

An attempt was made in the accompanying table to indicate the emphasis as it occurred in the two patients. Following this the broad groups in which the ideational content falls will be considered in detail.

Topic	Case I Times referred to	Case II Times referred to
Father	17	13
Mother	9	7
Others: in family	34	11
Others: outside family	17	12 (physicians 9)
Heterosexuality	5	5
Homosexuality	1	11
Onanism	3	..
Sexual inferiority	2	2
Painful events	15	12
Activities and plans	15	12
Death, rebirth, reincarnation	15	a few
Symbolism, modern	27	12
Symbolism, archaic	30	12
Misidentifications	14	..

1. The parents or their surrogates played an unusually large part in the mental content. The first and older patient referred less to his parents than did the second but the character of the remarks was similar. Neither had satisfactorily emancipated himself from his infantile attitudes towards his parents. This was obvious in their life histories and clearly demonstrated in their utterances during the manic reaction. The first patient, who was in his fifth decade, had average life accomplishments as a background but in tracing his life history one sees very clearly how necessary it was

in later life that he have paternal and maternal surrogates who were kind.

The manic patient, in his attitude to those about him, seems in general to take for granted their kindly and tolerant attitude; that is, he expects privileges, gratuities, and that his demands will be granted as a matter of course. When there is opposition or frustration, irritability, pugnaciousness and a hostile attitude are apt to result. This attitude is analogous to that of a child of five or six towards his parents. In manic patients the ambivalent attitudes towards the objects of their interests are marked. The ministrations of those who subscribe to their wants, who flatter them, who meet their demands are accepted as a matter of course. Their denial is apt to be followed by a hostile reaction and attitude.

An excellent example is seen in excerpts from the letter of a 17-year-old manic patient to his parents. There is also shown the oral nature of the patient's wishes. This patient at the time of writing these letters was capable of carrying on a fairly intelligent conversation, showing much insight. In his letters to his parents he started off well enough but invariably his sentences would deteriorate into denunciations and scoldings because of lack of response to his requests, into request after request for food, cigarettes, etc., and into long citations of his accomplishments, with much printing, underlining, cumbersome phraseology and many repetitions. "My dear parents: I didn't receive any mail today. What is the trouble? (Then after a few sentences the character of the letter changed.) Listen, please be so kind as to send me some pears, grapes, good Chinese apples, plain apples, bananas, assorted cakes, (etc.)—other people have fruit (and eight other items). I sit in the toilet and cry while others eat sweets, candies, chocolates, cakes, and cry, cry, cry." He goes on for one-third of a typewritten page in this vein. Another example from another of his letters reads: "The Ten Commandments say to respect your father and mother. They fail to cover the reverse situation; attitude of proper nature of parents to young college senior—age 18—scholastically high graded, a member of Arista," and so on with a long citation of his medals and accomplishments. He tried to arouse sympathy by cit-

ing long series of physical complaints. "My appendicitis might burst like Uncle Isaac's and then my life will be in serious danger. I cry silently, sadly, despondently, weepings, heartaches."

The literature contained considerable having to do with the attitude of the manic patient towards those about him, particularly towards the mother, and towards the environment. Abraham[2] stated that there was a hostility directed against the mother but primarily against the father. Eddison[12] referred to the hostility against the mother as being reflected in the hostility against the environment consisting of hospital personnel. Radó[38] seemed, in the writer's mind, to properly indicate, not in so many words, but in his whole concept, that this hostility was primarily directed against the unkind parent, against anyone who by act or inference tended to disagree or hinder the narcissistic gratification of the patient. The manic-depressive individual in his prepsychotic personality carries over certain infantile tendencies and his adult reactions in general are more insecure. Rather easily there may result regression to earlier forms of reaction under stress, particularly when there is an alteration in the relations of the people about him towards whom his affections are directed. In the manic phase it is felt that all those who have anything to do with the patient's needs, and this includes parents, physicians, nurses and others, are the recipients of attitudes on the part of the patient which are selfishly determined. To the manic patient the physician is a fine fellow if he spends time with the patient, listens to him and is agreeable. He tends to ascribe to the physician unusual powers, just as he does to his father. This may reach an extreme degree and he may, as did the first patient, refer to the physician as God. (When this patient was asked, "Why do you call me God?" he said, "Because you are kind to me"). The second patient ascribed to the physician unusual powers. Concerning one (actually frail) male nurse he said, "I can tell that he knows how to handle rough stuff and I know better than to try to pull anything."

That fundamental attitude towards the father which may result from a castration threat was manifested in the first patient. This patient referred many times to his recollection of his circumcision when he was four. Retrospectively he said that as a child he had

considered that his father had played a trick on him. There were subsequent references to being kicked and fear of injury to the genitals.

Remarks concerning the mother were numerous but less so than concerning the father, and in both patients there was a close attachment. The first patient slept with his mother until 11 and in his manic state he referred more than once to sleeping with his hand on her breast. The father slept upstairs and the patient had nightmares involving ogres. The indications are that the mother attachment was strong.

The siblings were mentioned less frequently and their signficance has been indicated. The first patient's relationship towards his four-year-old son had several aspects. The child was a proof to him of his potency. His attitude towards the boy was maternal, and one of oversolicitude. (He would bathe him, check up to see that he was clean; he would rush him to a physician for slight indispositions). There occurred definite jealousy once when the boy was taking a nap on the couch with the boy's mother; and the brief phantasy occurred to the patient that the boy might have been having sexual relations with the wife(a retrospective statement).

This patient's misidentifications were numerous. He confused males for a certain bishop (whom he admired and whom he wished be married to his sister) and for C. (an acquaintance he knew in private school, a boy whom he did not know well personally but who was aggressive, self-confident, and somewhat of a bully, a boy the patient envied and feared. This boy evidently kicked the patient once). Another male was misidentified as a college friend who was killed in the World War. Males were also called God, or father. Females he called by the names of mother, but usually by the name of girls he had liked, particularly those known earlier in his life.

In brief, the parents were found to occupy a large portion of the ideational content. These manic patients carried with them a picture or an ideal of kind parents and easily transferred their feelings concerning them to their surrogates, and in the manic attack proper, to the people in the environment. The attitude was one of ambivalence, being friendly and contented when their personal de-

mands were granted and being hostile and angry when their demands were refused.

2. The statements of the patients indicated difficulties in their psychosexual development. Certain contributors, notably Lewis and MacCurdy, have stressed the insecurity which manic-depressive patients show as regards their sexual status. The incomplete resolution of the Oedipus conflict in early life, the strong love and hate tendencies, the homosexual component and the narcissism and dependence tend to determine later selections of objects of affection and to influence the relationships to other people.

The first patient in his remarks indicated his attachment to his mother, the determining influence in the choice of subsequent recipients of his love, the identification of himself with his mother in relation to his wife and son, the strong but well-sublimated homosexual tendencies, and with all this more than the usual degree of narcissism. There were references to fear of harm to the genitals. There was a distortion of one incident which can only be related to his uncertainty of his sexual status and his wish to be a woman. This incident had to do with the curettement of a suprapubic cyst. He wondered whether the curetted cavity might not be analogous to a vagina. The carbuncle itself he thought might be analogous to the clitoris in the female. He said that he derived this idea from his mother. This was probably a retrospective falsification but such a statement would indicate that there was an early childhood notion of a female phallus belonging to his mother.

The second patient exhibited a strong attachment to his mother, showing a certain degree of identification with her in his attitude towards his father. There was a strong homosexual component of a passive type. The patient's statements with the accompanying comment have indicated this already. The narcissism was indicated by the total life picture. He failed to develop essentially beyond the homosexual level and remained to a considerable extent in the period of narcissism.

3. The ideational content of these patients referred to external activities, work, and plans to a sufficient degree to reveal, on the one hand a difference between their concept of such and the con-

cept of mentally well individuals, and on the other hand the extent to which such factors were involved with their own psychological problems.

The first patient had attained average success in the teaching of mathematics. The infantile roots of his interest in mathematics began in his interest in childhood in building blocks, with interest in form and symmetry. An adolescent interest in naval architecture, which was given up because of lack of certain credits, combined his interest in water and boats with his architectural interests. Subsequent choices which he considered were the ministry, teaching medicine, and osteopathy. His father preached and taught Hebrew. He had received both the care of physicians and osteopaths. His first teaching of high school boys was followed by disciplinary trouble. Later he worked as an accountant and bookkeeper with success. He returned to teaching high school mathematics, continued to have disciplinary trouble with boys, and eventually found his best results in teaching the more fundamental mathematical branches to college students. He chose a rather abstract topic for a thesis in a branch of mathematics directly connected with his childish interest in building blocks. In his college teaching he enjoyed the kindly interest and direction of his superiors on the one hand and on the other devoted an unusual amount of time to the coaching of backward students. His chosen profession was quite intimately bound up with his particular psychological needs and problems. Some indications of in what manner this was so may be given. His teaching superiors and the college itself functioned as a kindly but strict parental substitute. His friendships with certain fellow teachers were quite strong, furnishing a socially acceptable outlet for his homosexual tendencies. His attitude towards his students was a parental one, and the backward ones he tended to identify with himself, coaching and feeling sorry for them. College functioned as an artificial home circle. Mathematics itself appealed to him because of its geometric aspects. He loved nature, and quoted an old saying, "Nature ever geometricizes." Through mathematics there was furnished an outlet for certain tender emotions. His interest in mathematics was supplemented by church and fraternal activities.

This patient in his remarks indicated that in his adolescence his father had wanted him to be a minister and his mother had wished him to become a doctor. He remarked: "I don't see why you couldn't be both at the same time." In his manic state he wished to please both parents.

His references to mathematics in his psychosis were almost altogether expressions of his psychological problems in mathematical terms. "I love mathematics so everything is mathematical to me." He conceived of himself as having two personalities, expressed as two circles, A and A-prime. The concept of one to one correspondence, he said, applied to the two sexes, with anatomical parts to match, including testicles for ovaries, penis for vagina. He described numerous geometrical figures in the air to symbolize or to effect some result in a magic manner.

The second patient presented a fortunate contrast to the first in the matter of age. This patient, however, had at the age of 23 accomplished very little in life. He too completed college with difficulty because of mental illness. There was a history of an active social life in college. He belonged to a fraternity. Yet on closer study his extroversion was more apparent than real. It constituted an attempt to cover up his feeling of inferiority, to make up for his highly pitched voice, pale skin and blond hair. His wish to become a journalist, was superficial, representing a reaction to his father's wish that he become a lawyer. To his father's wish he acceded and shortly developed a manic-depressive reaction. His extracurricular activities were for the selfish purposes of increasing self-esteem rather than for pleasure from the activities themselves.

His remarks while under study concerned medicine, psychiatry and law. Reference to his actual statements indicated that in his manic reaction his objectives changed from day to day, he identified himself with the physician in wanting to be a doctor. The motives which he expressed were quite altruistic; his prime object seemed to be to help others.

In this case, as in the first, there was no "flight into reality" in the true sense. The references to plans, life activities were all based on identification, his desire to help others, and in the final analysis were attempts to raise his self-esteem.

4. The patients referred again and again to events and life situations which were of a painful nature and which constituted psychic traumata.

The first patient referred to his circumcision at the age of four when his father gave him the chloroform. This incident has been discussed and it is necessary here only to emphasize how vivid the memory was in his mind. Other traumatic experiences referred to were teasings, bullying by older boys, physical assaults by the brother, lack of a home and adequate home to which he felt that he could bring friends, rejection for army service, acne, and previous mental illness.

The second patient was less productive concerning his early life but one experience seemed particularly significant, and was mentioned rarely but with considerable emotion and incoherence. This referred to the witnessing of the death of his sister when he was eight years of age. There had been within the two previous years sexual play between the patient and this sister. Some of his statements follow; the word 'sister' instead of the girl's name will be used: "Misfortune occurred on the street that ran east and west—Sister's accident—Oh the hell with all this symbolism—A childish curiosity, a beautiful child. Oh, another thing. I giggled at her funeral. Since that day I've hated vanilla ice cream. (He spits on the floor. He ate some ice cream shortly after the accident.)—Well, I was almost wedded to my sister. It was the wrong kind of curiosity. Write this down for future reference, teeth and penis." "I was very badly upset by my sister's death. I can't explain why. I tried laughter. It may have been compensatory laughter." "At (college) I was having relations and suddenly I would think of my sister." About three weeks later during a period in the continuous tub he gave spontaneously, along with a variety of other verbal material, a minute account of the accident. In telling it he wept loudly and expectorated several times.

This patient spoke feelingly of having been a puny child, of having had to attend fresh air school, and of his recurring otitis media in childhood. Such incidents tended to reinforce his narcissism and increase his feeling of physical and general inferiority.

5. The ideas which have been expressed concerning death and rebirth found their most free expression in the first patient, the one showing the deeper regression. Such statements were made when both patients were preoccupied and were paying relatively little attention to what was going on about them; the first patient did distort objects within his field of vision to fit in with his ideational content at the moment. For example, he referred to a tree outside the window as the cross on which he was to be crucified.

It is the writer's impression that ideas of death in general mean the same to manic-depressive patients, and that these ideas are more prominent in stuporous states associated with depressions or in temporary depressive states in the manic reactions. In the latter such ideas seem more apt to occur when the patients are so engrossed with their own thoughts as to be in poor touch with reality. The ideas of rebirth seem to follow the idea of having died, and are apt to be associated with the vague concept of reincarnation, meaning death with a return to life.

The first patient expressed rather clearly the feeling that he was being put into a coffin instead of a tub, and that he got out by the use of magic motions. He then felt exhilarated, and afterwards said that at the moment he felt briefly that he was Christ. (Other references to dying and rebirth ideas have already been given).

The second patient said in retrospect that when he was emerging from his depression the nerves in his eyeballs, which during the depression had seemed to be rotting and disintegrating, were felt to be knitting, and that in a similar manner the segments of the brain were piercing themselves together. This state, he said, was associated with a religious experience. "At that point I was thinking of 15 things at once, of father, mother, God, baptism, revelation, a sort of rebirth." These statements in themselves can furnish only hints, but it may be suggested that in the sequence hypochondriacal delusions—regeneration of rotting tissue—increase in interests and associated with these the development of a manic picture, with the admixture of a religious coloring—there was occurring the same symbolic sequence of death and rebirth. In this second patient however there was a less severe regression, he was

in better touch with reality. The symbolic use of eyes and brain (and ear) probably represented a displacement from the genitals upward.

Those patients who show a lesser degree of manic symptomatology are apt to make no statements concerning death and rebirth. One boy of 16, however, with a lesser degree of regression than either of the above patients, did express such ideas, ideas almost within the realm of normal figures of speech. On admission he was in a perplexity state, saying "I'm a good boy. I didn't mean to do it." (He had been arrested in a stolen car several weeks previously, at which time he was definitely hypomanic.) He felt that this hospital was a prison and that he would be put in a coffin. Within a few days he became hypomanic, and several weeks later became for the first time actively and typically manic but without any confusion, symbolic expressions, or evidence of deeper regression. Some of his ideational content while he was in the continuous tub was as follows: "I want to forget. Be reborn. I'm through with the old life. What I want is a mental rebirth. It is so every day. Protoplasms are always multiplying. Life begins when you want it to begin. I want to prove to my parents that I can do something. I'll write out my new name for you, Bruce B. H. L. (representing his real name) is dead. H. L. is too Jewish—You've got a coffin waiting. H. L. is in it. I'm living a new life from now on. (A patient in another tub) S. is asleep. (True.) Sleep is death."

This patient in a perplexity state expressed ideas of death associated with punishment for his past sins, and was fearful of his environment. When he was manic his concept of death involved denial of a past with painful memories, and rebirth into a new life. He used the term rebirth as a figure of speech to a certain extent but at the same time spoke with such assurance and belief that he seemed to actually believe that a new life was beginning.

Dying, one feels, means to the manic patient the abandoning of an inferior state. Where there is marked regression the change to the superior state which follows may be accompanied by megalomanic ideas such as Christ identification or absorbing power from God.

6. Numerous archaic ideas were expressed and dramatized. These were manifested more openly and to a more primitive extent in the first patient, while both exhibited numerous symbolic identifications, which though archaic, were of a somewhat higher order than is sometimes seen.

The first patient dramatized his identification with the cosmos. He took a posture which to him represented a tree; he was erect; the arms were extended horizontally. He said that he was a tree. He acted in accordance with the primitive belief that man's soul after death is buried in the earth, goes into a tree, and that there is in this way a rebirth into nature, a sort of reincarnation. He expressed this idea at the time and in retrospect several weeks later.

His fear of and apprehension concerning what was strange was analogous to the fear of savages of any unexplained phenomenon.

In the more profound regression the references to sex were no longer spoken of in the usual manner. The sexuality which was present was that appropriate for the infantile or even the intrauterine period. (A boy under puberty in primitives is considered to have no sexuality, and is given a name meaning "just like a girl," meaning that the girl has no sexuality, the boy therefore having none.) There was, however, a cosmic identification involving the participation of cosmic forces such as the sun, a comet, electricity, dynamite, and these constituted a threat of annihilation or death to all; he expressed the fear of a comet hitting the earth, fear of a world catastrophe, fear of a world war. In other words, forces in the environment threatened such a peaceful identification with nature. Nature represented his mother. This seems to have been a symbolic way of expressing a real concrete everyday threat to him, the threat that originally comes from the father.

The symbolic expressions and behavior of a higher order were expressed in many ways, varying from more regressive forms such as indicating perpetual motion by nodding the head or revolving a cup—to such questionable ones suggesting normal figures of speech as referring to the individual as a dual personality, A and B. These manifestations were present in both patients.

V. Summary and Conclusions

The manic phase of the manic-depressive reaction has been the subject of psychological investigation. The objective has been the study of clinical case material in order to describe those psychological mechanisms which were present. This study was preceded by a survey of the literature. In this survey the development of the manic-depressive concept was first traced, and then those contributions which have seemed of merit were reviewed. This review was limited to a consideration of the manic reaction from the standpoint of etiology, symptomatology and psychological mechanisms. The clinical investigation was centered about the ideational content of two representative manic patients. There were found to be indicated in this ideational content a rather limited number of topics. The critical observations followed the lead suggested by the general scope of the patient's remarks, and there were considered, in order, the rôle of the parents, psychosexual growth, environmental objectives, psychic traumata, ideas of death and rebirth, and symbolism —modern and archaic.

The conclusions which are expressed, it is believed, apply not only to the patients who were studied in this communication but are applicable to the understanding of the manic reaction in general.

1. The manic reaction represents one solution or "way out," in the attempt of the patient to solve his particular problems. The goal seems to be a state of narcissistic satisfaction or happiness in which painful ideas are denied, the inferiorities are compensated for, and the ego is omnipotent.

2. The manic reaction represents a regression to early expressions of narcissism. The symptomatology indicates the degree of regression. The symptomatology contains many references to early childhood forms of thinking, acting and feeling; for example the patient's attitude towards parents or parental substitutes, and the concentration of interests upon the individual himself with consequent overvaluation of himself. As regression deepens there may be many references to early physical interests such as those related to the oral and anal zones.

3. The attitude towards those in the environment is a selfish one serving in its several aspects the narcissistic needs of the patient. The parents principally, and others also, function as individuals who may or may not gratify the patient's demands and impulses. Ambivalence which is so well developed in the manic reaction is expressed with a kindly feeling when demands are met, and with hostility when the demands are denied.

4. The psychosexual status of the manic patient is made clear in his ideational content and behavior. In general, his original relationships to his parents have been retained and the Oedipus situation is poorly resolved; there is an inadequate heterosexual adjustment which is accompanied by an increased homosexual component, perhaps well sublimated. The bisexual constitution tends to be exaggerated; this is shown during the regression and may at times constitute an important part of the clinical syndrome.

5. It should be emphasized in closing that only psychological mechanisms have been investigated. It is believed that the pathology of the psyche is not the only pathology present in the manic-depressive psychoses. No attempt is made to correlate or evaluate the psychic factors in their relationships to the physical, hereditary or other aspects.

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BOOK REVIEWS

Autobiography. By SIGMUND FREUD. Translated by James Strachey. W. W. Norton and Company, Inc., New York. 1935. 153 pages. Price $2.00.

We are fortunate to have from the pen of Professor Freud this contribution which clarifies and rounds out the story of psychonalysis. He was never one to shrink from disclosing his intimate life when by so doing he could contribute something important to be revealed for psychoanalysis. In this small book, with characteristic modesty, he tells of the origin of his theories and his early struggles; of his ostracism by medical colleagues of Vienna and of his fruitless efforts to be heard and understood by them who rejected him. For six years no voice was raised in his support. Hardly a journal would review his earlier books; the medical world seemed determined to crush and ignore him. Even Bruer, of whom Freud speaks only in kindness and gratitude for his early assistance, abandoned him when the hue and cry became too vociferous—Bruer, who lacked the vision to recognize the fundamental truths of what he himself is generously called the pioneer, recanted his part and fled to the security of his lucrative practice. Freud tells with sadness of the defection of two of his early pupils, Jung and Adler, and explains why he can no longer recognize them as spokesmen of psychoanalysis.

That Freud was obliged to endure the ordeal that has been imposed upon pioneers since the scientific world was first called upon to reject outworn dogmas and to accept new ideas, should hardly occasion surprise. It was inevitable. Since Galileo was condemned as a heretic and his writings ordered burned by the ecclesiastical court, the list of martyrs to the advancement of learning is a long one. Harvey, Jenner, Lister, Hack Tuke, to mention only a few, suffered ridicule, derision and personal abuse from —whom? From contemporary scientists, from scientific journals and leaders of thought of that day. The world-wide tirade let loose upon Charles Darwin by men of science and theologians has more resemblance to that aimed at Freud than to the others mentioned. Darwin's Origin of Species and Descent of Man were characterized as "a jungle of fanciful assumption," "utterly unsupported hypotheses," "cursory investigation," and

himself "reckless and unscientific." We have heard and read just such anathemas pronounced against psychoanalysis and Freud. How many times too has Freud been confuted, disproven and dismissed by those who had not bothered to understand him. One is reminded of the Boston Religious Magazine's announcement in 1873 that "The Rev. Mr. Burr (*sic*) had demolished the evolution theory, knocking the breath of life out of it and throwing it to the dogs." In much the same way was psychoanalysis demolished and thrown out of court in a presidential address before the American Psychiatric Association about 20 years ago.

A resemblance also pertains to the personality of Freud and Darwin; both were silent men with little relish for publicity; both were gifted with scientific honesty which made the pursuit of truth paramount and enabled them to put aside the odium of contemporaries and look to another generation for confirmation, knowing that it would prevail in the fullness of time. Freud tells us in his autobiography that it was at his entrance to the university that he first perceived he was expected to feel a sense of inferiority because of his Jewish origin, but as he was not conscious of mental or physical inferiority the result was only that he acquired a contempt for the judgment of others about himself which must have supported him in later years.

Darwin's fiercest critics and denouncers were the ecclesiastics, while Freud and Lister endured ostracism and contumely from co-workers in the field of medicine. The first two have something else in common and more pleasant to remember—each lived long enough to hear himself proclaimed a benefactor of science and to witness the humiliating retreat of his enemies. In America at any rate, no medical man of authority seems now to remain hostile to psychoanalysis, or if he does he has been silenced. It is only the Ph. D.'s who still patiently point out Freud's "errors" and "set him right." The old psychologies are still gagging over the bolus of depth psychology, but it will go down even should their own disintegration be the result.

On May 6 of this year will occur the eightieth anniversary of the birth of Sigmund Freud. On that day, the American Psychiatric Association will be in session in St. Louis. The program to be presented there will doubtless reflect in no uncertain way the contributions of psychoanalysis to the advancement of psychiatry.

Building Personality. By A. Gordon Melvin. The John Day Company, New York, 1934. 303 pages. Price $3.00.

It is high time for some one to bring order among the psychologies. Dr. Melvin is not afraid to make the attempt but whether his effort will gain support among his confreres or he will be accounted a trouble maker—an iconoclast, remains to be seen. At any rate he has rendered a good service in calling attention to the uselessness of much of the psychology still taught in our colleges. The reviewer remembers with what eagerness he turned to psychology in preparation for medicine, in the expectation that it would aid him in understanding his prospective patients, and his disappointment when it taught him nothing he cared to remember. Dr. Melvin's opening discussion is along this line and it will be applauded by physicians who have had the same experience. Teachers and social workers should be interested in his treatment of the theory and practice of intelligence testing. He distinguishes intelligence from "brightness" and illustrates by the example of a clever burglar whose brightness had given him a complete understanding of the mechanism of safety locks and who would be rated high in the Binet-Simon test. His gift, however, is only brightness, for he may spend many years in prison, a fate which an intelligent man would take care to avoid.

The author's main theme is the personality as a whole, in which he is fully in accord with modern psychiatric conceptions, and proposes an integrated psychology which he believes might make use, in its composition, of whatever the academic psychologies can contribute and he finds that all have a contribution to make except the behaviorists. The latter are anathema. His treatment of the Freudian psychology is sympathetic. He attributes value to the analytical method. Its field had never been entered by the earlier schools and a store of knowledge essential to understanding personality had not been touched by them. The author postulates a force which he calls the "life force" or the energy of the personality. He cannot accept Freud's term libido as anything more than one of the elements of this life force. By an "extraordinary error" on the part of Freud he blundered into mistaking a part for the whole. Nor is the author quite clear in his understanding of the Freudian unconscious; witness the following: "The concept of the life force sucusing the personality makes unnecessary any such separate division of the personality into the conscious and unconscious." (p. 261.)

He devotes just a page to Adler, of whom he seems to approve because "he has gone somewhat farther" than Freud. Jung, too, is credited with additions to and improvements upon the Freudian position. While orthodox

psychoanalysts will hardly concur in his appraisal of the three pioneers, they would recognize that the author is by no means hostile nor is he superficial. That he interprets Adler and Jung better than he does Freud and reviews their positions with greater understanding is because he must lack the experience of actually working with psychoneurotics. The reviewer knows of no academic psychologist, who has not himself been analyzed, who does not reject Freud's libido theory. The two known to him who have experienced analysis, accept it.

It may be invidious to select one small portion of Dr. Melvin's excellent book for criticism but this review is for psychiatrists who will be most interested in that portion. When they read the book they will perhaps conclude that when the new synthetical psychology is formulated, psychoanalytic psychology, which is itself yet in its infancy, will be the cornerstone. Other schools—gestalt, introspective, physiological, purposivistic and even perhaps the behaviorists may add to the superstructure but the Freudian, recognized by Dr. Melvin as depth psychology, must of necessity be its basis.

Building Personality is a stimulating book, its insistence upon recognizing the personality as an integrated unity is perhaps its keynote. Physicians who hastened to forget the psychology of college days will read with interest this caustic but comprehensive review and criticism of the schools of psychology of today.

A Dynamic Theory of Personality. Selected Papers. By KURT LEWIN, Ph. D., Translated by Donald K. Adams, Ph. D., and Karl E. Zener, Ph. D., Duke University. McGraw-Hill Book Company, Inc., New York and London, 1935. 273 pages.

The former professor of psychology at the University of Berlin, who last year was acting professor at Cornell University and this year is visiting professor at the University of Iowa, presents in this volume the broad outlines of a new theory of personality, and fits into it many of the important researches of his former associates and himself. His chief interest is in formulating a theory which will make possible a strictly experimental approach to the study of personality. Hence he is concerned with methodology, and the first paper is devoted to an excellent review of the inadequacies of Aristotelian modes of thought for the science of psychology. It is more than this. It is an introduction, for those who are interested, to the revolutionary changes in thought-forms which are already established in the physical sciences.

As long as the concepts with which we seek to study human beings are "valuative" or quality-designating, we can essentially go no further than

to classify individuals according to whether they do or do not possess a given quality. But human beings are more than museum pieces to be labeled; they are moving and active. Hence to study human beings fully we must use descriptive and dynamic concepts. Lewin is concerned with finding such concepts.

For those actively dealing with mental cases, personality problems, and above all children, the book is full of stimulating suggestions. The latter half is devoted to an application of the theory to many aspects of life. An enumeration of the titles of these papers indicates their scope; Environmental Forces; Reward and Punishment, Education for Reality, Substitute Activity, Feeblemindedness.

To indicate in the briefest manner a few orienting points of the theory: (1) personality and environment cannot be separated fundamentally, and concepts must be found by which both can be described at the same time, (2) concepts based on the new branch of mathematics known as topology are used, as well as fundamental gestalt concepts, (3) frequently-used concepts are "field of force," "direction of force," "tension" (opposition of forces), positive or negative "valences" of objects, "barriers," "levels of reality" (considered as a "third dimension" of personality).

Whether these concepts will stand as they are, or will ultimately be modified, time and further study will determine. There is no doubt, however, that these concepts are dynamic, and that those which replace them, if any, will likewise be dynamic. The theory is a framework, not a completed structure, but one cannot read the book without feeling that at last experimental psychology is on the way to grappling with fundamental life problems.

The final paper is a survey of experimental investigations, most of which are by foreign scientists and hence less generally known by American workers. Those to whom the work of Lewin is unfamiliar will perhaps find it profitable to glance through this survey first, and then start with chapter III or IV, leaving the first two chapters until later.

What makes this book so readable, and the acquisition of its theory so easy, is the constant reference to actual human behavior. It is a significant production. Dealing as the author does with the problem of concepts it is apparent what a difficult task faced the translators. Drs. Adams and Zener have succeeded admirably in their translation of the author's thought as well as his words.

Some books are epilogues to a period of human thought. Some are prologues. This is a prologue.

Aphasia. A Clinical and Psychological Study. By WEISENBURG and MCBRIDE. New York, The Commonwealth Fund, 1936. 634 pages.

The authors have undertaken the important task of reviewing the question of aphasia and they present us with a very detailed work on neurological and psychological studies of case material.

Their book begins with a critical survey of modern work, the history of aphasia, and the elaboration of special problems connected with tests and examination methods, improvement and re-education, apraxia, agnosia and amusia.

The authors have investigated a total of 314 cases of which 234 were examined. A control group of 38 cases was used for the study of unilateral cerebral lesions without aphasia and a control group of 85 normal adults is also included in their survey. The principal tests used in detecting aphasic manifestations consist of tests intended to study speaking, naming, repeating, understanding spoken language, reading, writing, arithmetic, language intelligence, the production of verbal material and the known language tests.

From the clinical standpoint, the authors classify aphasia into four groups:

(a) The predominant expressive group; (b) The predominant receptive group; (c) The expressive-receptive group; and (d) The amnesic group.

In the predominant expressive group are the most numerous cases, 43.3 per cent. The group is homogenous, in that it is comprised of patients whose most serious disturbances are in spreading or writing or in both forms of language expression. The predominant receptive group is constituted by a relatively small number of cases, namely 28.3 per cent and consists of cases in which there is a more or less marked limitation in the understanding of spoken language and printed material. The expressive-receptive group, represented by 20 per cent of the material studied, discloses very serious conditions in all language performances, expression and reception. In the amnestic group are included only five cases or 8.3 per cent. The fundamental difficulty consists of evoking words as names for objects, conditions, or qualities thus leading to serious limitation in speaking and writing and characteristic disturbances in other language performances.

In addition to the classification which from a clinical standpoint covers most of the varieties of aphasic manifestations met in neurology, an interesting contribution to the authors' work for practical problems of diagnosis and treatment is the establishment of a satisfactory system of examination. The battery of tests which they have outlined in chapter VI of the book, in

particular when patients are many and time is short, may be abbreviated as described in their appendix 2 in a series of tests which may give the extent and nature of the disorder in a few hours.

A second contribution of their investigation as mentioned by the authors themselves, is the comparable study of normal adults and the more accurate determinations of the aphasic disorder consequent thereon. Presenting as it does a satisfactory sample of the average middle-level adult, this group not only serves as a basis for the estimation of the disturbances shown by the aphasic and non-aphasic cases of cerebral lesion but it could well be used for further studies of normal adults with possible changes in mental functioning, for example for patients suffering from any of the psychoses, dementias or encephalitis.

From a practical standpoint, the suggestions for the re-education of aphasic patients contained in the book are of considerable interest.

As to the significance of the findings for an understanding of the nature of aphasia, certain definite statements can be made. With regard to the pathological subtratum it is clear that the lesions must be in a given area which include both the posterior and anterior parts of the brain. By the anterior part the authors mean the precentral convolution and the adjacent part of the frontal lobes, the premotor area. By the posterior parts, they mean the inferior parts of the postcentral and parietal lobes, the superior part of the temporal lobe and the anterior part of the occipital.

In all their cases of expressive aphasia, the lesions involve the anterior and to a less extent the posterior parts of the brain. In the predominant receptive group, the lesion includes the anterior as well as the posterior part of the brain, the posterior being more implicated than in the expressive group. In the receptive-expressive group, both the posterior and anterior parts were equally involved. As for the amnesic type, no definite statement is made because of the very few cases available.

As the authors point out, if pathological inferences are permissible from the psychological results it is pertinent to point out the following conditions:

(1) The chief psychological changes consist of:

(a) Predominant disturbances in language; (b) disturbances in so-called non-language activities; (c) alteration in common everyday social behavior.

It is obvious that the psychological language disturbances have as their basis a pathological lesion in the area defined above and that the type of disorder is dependent on the site, extent and nature of the lesion. It is also necessary to point out that a lesion anywhere else, but within the

limited region crudely outlined, does not produce aphasia. From this standpoint at least, the negative findings are more important than the positive.

(2) While it is impossible to determine any specific areas underlying non-language activities, it is clear that although they are to some extent dependent on verbal formulations, that is, on the locale of the lesion in the area described above, they may be partly or altogether independent of language. They undoubtedly require the normal activities of both hemispheres. An original lesion in the language area may lead to disturbance in non-language performances, without predicating a separate pathology.

(3) What has been said about non-language activities is equally true of everyday practical and social behavior, that is, both hemispheres subserve such behavior and lesion in the aphasic zones may bring about the disturbance of normal activities in these fields.

Altogether the book represents a serious and painstaking effort toward a better and concise exposition of our widely accepted conceptions of aphasia. This aim is obtained by the book, though no new approach is outlined for any additional understanding of the fundamental mechanisms of aphasia. But even though it fails to contribute to the pathogenesis of aphasia, the book contains a wealth of material concerning particularly methods of examination, methods of re-education and studies of the control group, to justify its place as a valuable addition to every medical library.

Psychology and Health. By H. BANISTER, Ph. D. Macmillan Company. New York. 1935. 258 pages. Price $2.50.

Addressed to medical students and general practitioners, the author's purpose is to arouse the interest of physicians in the possibility of being able to deal effectively with a group of disorders which they now do not comprehend and avoid whenever possible. He calls attention to the large number of mild mental and psychoneurotic patients encountered in the medical and surgical clinics who consume much time because their symptoms are baffling to the internist and surgeon, by whom the real nature of their symptoms is not recognized. He then proceeds in the following chapters to bring together what modern psychology has to contribute of more efficient methods for treating mental ailments which fall short of true psychoses. Dr. Banister is not a psychoanalyst but recognizes that there is no other effective approach to understanding and dealing with mental conflicts and their resulting symptoms than what may be summed up broadly as the Freudian psychology.

The views of Janet, Freud, Jung and Adler are discussed understandingly and without prejudice and in terms which are not difficult to understand. The author's wide experience with psychological disorders at the Papworth Village Settlement is utilized for examples to illustrate his theme, examples which can be matched in the experience of every family physician. He has found that as a rule conflicts can be resolved and the symptoms relieved without the necessity of referring the case to a specialist, but he cautions against attempting to treat compulsive states and conversion hysteria. Such should all be referred.

The author's discussion of the value and significance of psychology in advising parents in the management of children is sound and well expressed. The book will be of value also to social workers and clergymen in their daily work; its style is fluent and the reader's interest is maintained throughout.

Wayward Youth. By AUGUST AICHHORN, with foreword by Sigmund Freud. New York. The Viking Press. 1935. 236 pages. Price $2.75.

Aichhorn's success in dealing with wayward and problem children is well known. As director of an institution for delinquent children at Ober Hollabrunn, he developed a method of dealing with that type of individual which was a complete innovation upon that prevailing in other such institutions. His aim was to understand the causes and motives which were responsible for their asocial behavior and to resocialize them, which was all that was necessary for their reformation. He found that the insight to be gained by the application of Freudian psychology to the study of their conflicts made it possible to meet the children understandingly so that punishment and restraint were unnecessary.

This book is a translation by a group of his American students of his work *Verwahrloste Jugend*. In it he discusses his theories and experiences with entire frankness, illustrating them by numerous references to individual cases, some in considerable details. The physician or social worker connected with child guidance clinics cannot afford to miss the help which can be gained by the perusal of this unusual book. Physicians who have the care of mental patients also will learn useful lessons in understanding and dealing with the behavior problems which constantly arise in what are called the disturbed wards. They will see more clearly than before that the psychotic and the child have traits in common, and Aichhorn's successful approach to the child offers useful suggestions in dealing with psychoneurotics particularly, but also with more advanced cases of regression.

The Ordinary Difficulties of Everyday People. By JOHN RATHBONE OLIVER. Alfred A. Knopf, New York and London. 1935. 296 pages. Price $2.50.

John Rathbone Oliver, M. D., is well known as a clergyman and writer of books of a semi-medical character. One entitled Fear, published in 1927, had an extensive circulation. In his writings it is not always easy to discern whether in his capacity as physician he is addressing a congregation or as a priest he is advising in a psychiatric clinic. There are those who maintain that the dual rôle is appropriate to the calling of each. The popularity of mental hygiene clinics in connection with some metropolitan churches in recent years indicates that such a relationship is claimed. Sometimes a psychiatrist is available in them; in others, the pastor professes to need no such assistance.

Dr. Oliver is not to be classed with this group. Well trained as he is in medicine and psychiatry, he occupies a niche shared, so far as the reviewer knows, only by Father Moore.*

This is not a book written for psychiatrists. If one reads it with that expectation he will be disappointed. Its style is breezy, colloquial; he employs anecdotes and reminiscences to illustrate his meaning. Its value to physicians will be found to lie in the disclosure of the technique of the physician-priest in approaching, interesting and instructing those who are in need of guidance in critical situations; them he comforts, warns or admonishes as occasion requires. It is as much a book on philosophy and ethics as anything else. His material is drawn to a large extent from his experience in advising undergraduate students.

A psychiatrist would find flaws in his sometimes too sweeping generalizations which diminish the soundness of his conclusions but it would be useless to do that. Perhaps the critic would not do as well for by too close adhesion to scientific accuracy he could spoil the boon in its interest for whom it was written—everyday people.

Behavior Development in Infants. A Survey of the Literature on Prenatal and Postnatal Activity. 1920-1934. By EVELYN DEWEY. Published for the Josiah Macy, Jr., Foundation by Columbia University Press, New York, 1935. 321 pages. Price $3.50.

The preface states that publication of the book was made possible by a special grant from the Josiah Macy, Jr., Foundation. The survey presents and compiles the current literature on growth processes and infant behavior during the years 1920-1934. The research program of the Neurological In-

stitute (Dr. Frederick Tilney) in connection with the Normal Child Development Clinic has given the impetus to the book. We find in its bibliography 216 references which are considered selective as the author did not intend to cover all the literature but tried to organize the material according to the plan followed by the Normal Child Development Clinic of the Neurological Institute, New York City.

The first part of the book discusses theories of behavior development as represented by the behavioristic and gestalt psychological trends. Biology and neurology favor the "organismic" (agreeing fundamentally with gestalt psychology) concept of functioning. Research and literature concerned with correlation of structure and function from animal studies, stressing analogies with human behavior are referred to.

The second part of the book deals with behavior of the human fetus, the third speaks of neonatal behavior and the longest fourth section of behavior during infancy. The author offers to us a thorough exposé of the articles and findings of various authors and investigators dealing with behavior development during the fetal and infant periods. A very valuable summary and conclusions comprise the fifth and last part of the survey.

The author laments the fact that in spite of the great mass of data presented it has been impossible so far "to assemble a clear and conclusive picture of the total growth pattern or of the fundamental processes underlying it." We lack uniform and sufficiently objective methods and have not progressed enough in correlating neural structure and its development with behavior and its development. But the psychometric advances as well as the intense work in neurology and physiology are now opening a better vista for the studies of behavior development.

Some of the tests evolved in reference to infant behavior have proved useful clinically already. But uniformity is lacking. Remarkable work such as is done at the Yale Psycho Clinic, at Ohio State University, at the Neurological Institute, New York City, and other centers of child study, would further more rapid and efficient progress if some uniformity of methods of investigation could be achieved and if the neural, neuromuscular and glandular activities in the growing human organism would be given their due share. Emphasis should be laid on the important rôle of maturation in the nervous system in reference to the behavior development in infants. The author has purposely excluded from her survey and discussion the "social and emotional development since their very existence involves interpretations which lead us afield into theoretical speculations."

The book represents a welcome literary digest and a valuable reference book to those interested in and dealing with the genesis and evolution of

human conduct in relation to neural and somatic maturation and also as reaction to the environment. It may also be called a challenge for further research and more centralized and purposeful efforts of understanding the mechanisms of human behavior.

Nursery School Education. Theory and Practice. By WILLIAM E. BLATZ, M. D., M. B., Ph. D., and DOROTHY MILLICHAMP, M. A., and MARGARET FLETCHER. William Morrow & Co., New York, 1935. 365 pages. Price $3.50.

The well-known physician, psychologist and educator, Dr. Blatz in collaboration with his able assistant director, Dorothy Millichamp, and the nursery school principal, Margaret Fletcher, has presented to the public in theory and practice viewpoints and applications as they are realized in theid model nursery school in Toronto, Canada (St. George's School for Child Study, University of Toronto).

The principles of education in general, namely, the survival of the individual and the race with emphasis on the "social survival" are stressed. The social method of guidance, learning by doing and imitating together with the specific aim of stimulating learning and the offering of opportunities of learning "how to live" are placed before the reader. Successful learning will mean acceptance by the group, while not-learning will result in isolation. The nursery school should offer a chance to usher the preschool children into "the acceptable standard of the group as they grow up together" as soon as social living becomes apparent (about the age of two years). The teacher furnishes the arrangement for the learning process by motivating the child, by offering an environment with opportunity for experiment and by reducing interference to a minimum.

In this way the child will be successfully prepared to become an adult who enjoys living and will strive to make the compromise between his "conformity and individualization increasingly more efficient and pleasant."

The nursery school program of the St. George's School for Child Study is outlined in detail. We are shown how the child learns the nursery school routine by doing and conforming. The procedures as well as the discipline involved are skillfully discussed. The adult's unemotional attitude assists in the solving of problems encountered. The child's development through free and organized play and analysis of the required play material are laid open to us. The environment is above all planned to offer the child continuous development in social behavior. The children are allowed to face and solve their own problems. Appropriate behavior is substituted for inappropriate reactions. Constructive leadership is encouraged but the child is

also made aware of the right of his contemporaries the other child. Difficulties arising in organized play are treated by ignoring and by suggestion. The child's social adjustment is his own personal responsibility. Consistency in the method of handling emotional episodes is emphasized. The causative factors of the undesirable behavior should be fathomed, the child should learn to satisfy his needs in a socially acceptable manner. "The policy is one of prevention as well as cure." A positive approach is fostered. The treatment of physical discomfort, crying and other minor difficulties as well as more complex reactions such as fear, anger and jealousy, are efficiently dealt with. The child learns in the nursery school quickly that "emotional behavior is of no avail in warding off the consequences of his behavior."

Active cooperation between parents and school is an integral part of the nursery school program. Reports to parents, imparting to parents the child guidance attitude, associations with other parents, observation of the children in school, parent conferences, general and individual, all contribute to make school and parent a unit in the guidance of the preschool child.

A chaper about the child's diet and menus by M. L. Husband and a final chapter about physical health by Dr. F. F. Tisdall enhance the value of the book. Special attention is called to the useful bibliography and the practical record charts giving accurate minutae of the child's responses and progress.

Educators, parents, anybody connected and interested in sound child-rearing, especially those connected with nursery schools will welcome Dr. Blatz's book "Nursery Education." Those who have already benefited by Dr. Blatz's and Helen Bott's books "Parents and the Preschool Child" and "The Management of Young Children" will especially greet the present publication as an adequate guidance through the psychologically important childhood phase of life.

Female Sex Perversion—The Sexually Aberrated Woman as She Is. By MAURICE CHICKEDEL, M. D. Eugenics Publishing Company, Inc., New York. 331 pages.

In the aggregate this is a well-written and up-to-date discussion of morbid conduct phenomena. In a field in which psychoanalysis finds such fertile soil for application, the author's advocacy of that method of treatment is perhaps to be expected. It may likewise be anticipated that this predilection will color his attitude toward mental hygiene problems in general.

The writer assumes for discussion that "Unnatural deviation of the sexual instinct is a manifestation of a disturbed mentality" and "Abnormal sexual

practices are carried on to this day because perversions are not vices, but mental diseases, afflictions that enlightenment cannot cure." In such statements accuracy appears to have been sacrificed on the altar of generalization. The assertion that "hebephrenia and paranoia result from unsuccessful efforts to repress perverted instincts" is an inadequate solution, as it is only occasionally encountered; so simple an explanation of the causative factor of these psychoses will be accepted only with reservations by informed psychiatrists.

The psychological presentation is likely to have wider acceptance than the psychoanalytical interpretation. Theories of the origins of perversions and the psychological principles involved in the several forms, are described clearly and in logical sequence, together with an outline of recommended treatment. Typical cases are introduced to illustrate the aberrations and their corresponding suggested psychotherapy.

The author's theme will suffer from the categorical opponents of psychoanalysis and from psychiatrists who will object to the sometimes unwarranted generalizations, but in the main the book merits the attention of psychologists, psychiatrists, educators, clergymen, lawyers and social workers. It is not recommended for the general public.

Medical Social Work in Relation to Social Case Work. By HARRIETT M. BARTLETT. American Association of Medical Social Workers, Chicago, 1934. 223 pages.

In part one of its report the Committee on the Study of the Inter-Relationship of Disease and Social Maladjustment of the American Association of Medical Social Workers, of which Miss Harriett M. Bartlett is chairman, has given an interesting, helpful picture of the function and responsibility of a hospital, carried beyond its walls into the community. Such a service has been made possible by the growing emphasis on prevention in medicine. The report examines the special share as seen by themselves which the hospital social workers have in this public health program.

While the study was made by the association for its own group and "aims to explore the purposes, problems and methods of medical social work in its present stage of development," it has much to offer physicians, hospital executives, workers connected with the social service departments of psychiatric hospitals and community social workers.

The case material is well presented and the social worker's own critique shows courage and gives much material for constructive thinking on the part of the reader.

NOTES

—Dr. Clarence O. Cheney, director of the New York State Psychiatric Institute and Hospital, and president of the American Psychiatric Association, was recently appointed medical director of Bloomingdale Hospital at White Plains, N. Y. He will retain his position at the institute until June 30, the close of the present fiscal year.

—At the thirteenth annual meeting of the American Orthopsychiatric Association in Cleveland, Ohio, February 20-22, the social, biological and psychiatric implications of defective delinquency, mental retardation and feeblemindedness were discussed by outstanding psychologists and psychiatrists. A symposium was held on the 21st. The officers are: Ralph P. Truitt, president; Willard C. Olson, M. D., vice-president; and George S. Stevenson, M. D., secretary-treasurer. Lawson G. Lowrey, M. D., is editor of the quarterly journal of the association.

—The fourth series of Thomas William Salmon Memorial lectures will be given by Dr. Samuel T. Orton, president of the American Psychiatric Association in 1928-1929. Given on successive Friday evenings, April 10, 17 and 24, at 8 o'clock, at the New York Academy of Medicine, the lectures will have for their general title "Developmental Disorders of the Language Faculty and Their Psychiatric Import." In the order of their presentation, the individual lectures will cover the following topics:

I. Language losses in the adult as the key to the developmental disorders in children.
II. The syndromes of disorder in the development of language.
III. Treatment and psychiatric interpretation.

—On January 6, Dr. Walter N. Thayer, Jr., New York State Commissioner of Correction, died at the State institution at Napanoch. Dr. Thayer was the first superintendent of the Institution for Male Defective Delinquents of Napanoch, holding this position from 1921 to 1929, when he resigned to assume the duties of state superintendent of prisons in Maryland. The following year he was appointed Commissioner of Correction of New York State by Governor Roosevelt, and was reappointed to this office by Governor Lehman in 1932 and 1935. Dr. Thayer's addresses and writings on the subject of the betterment of penal institutions attracted nation-wide attention, and his accomplishments earned him the honor of being named president of the American Prison Association.

—The first week in May will mark the annual meetings of several groups at the Hotel Jefferson, in St. Louis, Mo.

The American Association on Mental Deficiency will hold its sixtieth annual meeting May 1 through 4. Friday sessions will be devoted to general sociological aspects of mental deficiency; Saturday sessions to psychological and educational topics, with especial stress on educational disabilities; and Monday sessions will be given over to research activities, medical aspects and administrative problems. The complete program may be obtained from the secretary, Dr. Groves B. Smith, Godfrey, Ill.

The ninety-second annual meeting of the American Psychiatric Association will take place May 4 through 8. Joint sessions have been arranged with the American Psychoanalytic Association, the American Psychopathological Association and the National Association of Private Psychiatric Hospitals, which societies will also be holding their annual meetings. Any group wishing a round table discussion not appearing on the preliminary program should communicate with the committee on program of the American Psychiatric Association. Copies of the preliminary program may be secured from Austin M. Davis, executive assistant, 2 East 103rd Street, New York, N. Y.

—An organization to be known as the Committee for the Study of Suicide, Inc., was formed last December, and incorporated under the laws of the State of New York. The committee, which may increase its present membership to 10 to a total number of 20, began activity early in January, in its plan to undertake a comprehensive study of suicide as a social and psychological phenomenon. To achieve this, a general outline was adopted, arranging for:

1. Intramural studies of individuals inclined to suicide in selected hospitals for mental diseases.
2. Extramural studies of ambulatory cases afflicted with suicidal trends or with obsessional wishes for their own death.
3. Social studies of suicide by experienced psychiatric social workers.
4. Ethnological studies—comprehensive investigation of suicide among primitive races.
5. Historical studies of suicide.

This committee was organized under the guidance of its first chairman, the late Dr. Mortimer William Raynor, recently medical director of Bloomingdale Hospital, who died on October 5, 1935. Its officers are: Gerald R. Jameison, M. D., president; Mr. Marshall Field, vice-president; Henry Alsop Riley, M. D., treasurer; and Gregory Zilboorg, M. D., secretary and director of research. The executive offices are located at Room 1404, Medical Arts Center, 57 West 57th Street, New York, N. Y.